(2)

No. 01-1274

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IN THE SUPREME COURT OF THE UNITED STATES

RCJ MEDICAL SERVICES, INC., *Petitioner,*

v.

THE DIRECTOR OF THE CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES, *Respondent.*

ON PETITION FOR WRIT OF CERTIORARI TO THE COURT OF APPEAL OF THE STATE OF CALIFORNIA SECOND APPELLATE DISTRICT

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. The sole issue presented by this case is whether the federal single state agency requirements of 42 United States Code ("U.S.C."), Section 1396a(a)(5) and 42 Code of Federal Regulations ('C.F.R."), Section 431.10(e) prohibit the California State Department of Health Services ("DHS"), the state Medicaid agency in California, from delegating to the California State Controller ("State Controller" or "SCO") the authority to perform Medi-Cal (the Medicaid Program in California) audits on behalf of DHS.

LIST OF PARTIES

The parties to the proceedings below were RCJ Medical Services, Inc., dba American Network Laboratory ("RCJ"), and the Director of the California State Department of Health Services ("DHS").

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JURISDICTION

This Honorable Court does not have jurisdiction to review the decision of the California Court of Appeal, Second Appellate District, for which the petition for writ of certiorari herein is being sought, *RCJ Medical Services, Inc. v. Bonta* (2001) 91 Cal.App.4th 986 ("*RCJ*") , which is reprinted in the appendix to the petition at 1-38.

The jurisdiction of this Court to review decisions of the state courts is codified in 28 U.S.C. §1257. (App. 79) This Court lacks jurisdiction to review *RCJ* by writ of certiorari because the jurisdictional prerequisites of 28 U.S.C. §1257 are not met.

First, under 28 U.S.C. §1257, Supreme Court review of state court decisions is available only with respect to "[f nal judgments or decrees rendered by the highest court of a State in hich a decision could be had." Following issuance of the remittitur n *RCJ*, the trial court held a status conference at which, over DHS' objections the court set a new briefing schedule and hearing on the merits for April 26, 2002 because the Court of Appeal had reversed the trial court's judgment without directions. (App. 63-70)[1/] The hearing has been continued to May 6, 2002. (App. 75-76) Petitioner, RCJ Medical Services, Inc. ("RCJ"), has argued to the trial court that the Court of Appeal's unqualified reversal of the judgment left the case "at large" for further proceedings. According to RCJ, the trial court should now decide the issue of whether, under controlling federal Medicaid laws, DHS may rely on the audit findings of the State Controller when the State Controller's audit predated the July 1, 1998 effective date of the State Plan Amendment which, according to RCJ, authorized the State Controller to perform Medi-Cal audits. RCJ contends that the Court of Appeal did not address this "very important and distinct issue," which " presents a separate

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1. "Pet." refers to the Petition for Writ of Certiorari herein, and "Pet. App." refers to the Appendix to the Petition for Writ of Certiorari. "App." refers to the Appendix to this Brief in Opposition to Petition for Writ of Certiorari.

question of federal law." (App. 71-74) This issue is the second of the two alleged federal questions presented for review by this Court. Thus, RCJ is simultaneously seeking this Court's review of the purported federal question while seeking judgment in the trial court on the very same issue. Therefore, according to petitioner RCJ's own argument to the trial court, the first jurisdictional prerequisite of 28 U.S.C. §1257, that there be a final judgment and that the federal question be decided therein, has not been met. (See, e.g., *Flynt v. Ohio,* 451 U.S. 619 (1981); *Houston v. Moore*, 3 Wheat. 433, 434 (1818); *San Diego Gas & Elec. Co. v. San Diego*, 450 U.S. 621, 632-33 (1981); *O'Dell v.. Espinoza*, 456 U.S. 430 (1982).)

Second, 28 U.S.C. §1257 requires that the final judgment must reflect a substantial federal question that has been properly raised and necessarily decided in the State Court proceedings. As set forth below, neither of the two questions presented in the petition was properly raised and decided below.

Third, the only potential basis for jurisdiction under 28 U.S.C.§1257(a) for this Court to review the State Court of Appeal decision in *RCJ* would be if "any title, right, privilege, or immunity is specially set up or claimed under the ... statutes of ... the United States." Without addressing the issue, RCJ assumes it has a federal right to enforce the provisions of 42 C.F.R.§431.10(e), which RCJ alleges requires DHS to audit its Medi-Cal claims. However, 42 C.F.R.§431.10(e) by its terms sets forth requirements for an agency to qualify as the state Medicaid agency. RCJ has no private right to enforce these provisions. (See *San Lazaro* (9th Cir. 2002) 278 F.3d 932, rehg. den. and sub. opn. (9th Cir.(Cal.)) 2002 WL 571674 ("*San Lazaro*") and cases cited therein.) RCJ also claims that jurisdiction exists pursuant to Rule 10 of the Rules of this Court. (Pet. 2-3) However, Rule 10 does not confer jurisdiction for this Court to review a state court judgment by writ of certiorari. Rule 10 merely sets forth considerations governing this Court's granting of discretionary review on certiorari.

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STATUTES AND REGULATIONS

The section of the petition entitled "STATUTES AND

REGULATIONS" fails to comply with Rule 14(1)(f) of the Rules of this Court. In this section, petitioner misrepresents the federal Medicaid single state agency requirements for auditing Medicaid claims by describing and paraphrasing mostly irrelevant federal Medicaid provisions in an inaccurate and misleading manner instead of complying with Rule 14(1)(f) by setting out the statutes and regulations involved in the case "verbatim with appropriate citation" or by "citation alone" with the pertinent text set out in the appendix . (Pet. 3-5)

The petition cites several Medicaid statutes and regulations [42 U.S.C. §1396a, subparts (a)(5) and (a)(9) and 42 C.F.R. §§431.610, 431.615, 431.621, and 431.630] as specifying "those limited exceptions where the single state Medicaid agency may delegate authority to other state or local agencies, ... all of which allow the single state Medicaid agency to enter into relationships with other state agencies." (Pet. 4) Petitioner lays the groundwork here for a later argument which incorrectly assumes that 42 C.F.R.§431.10(e) is a general prohibition against the single state Medicaid agency delegating authority to other state or local agencies and that the "limited exceptions" to this general prohibition against delegation must be contained in a statute or regulation.

There is no statutory or regulatory authority for RCJ's assumption that any delegation of authority by the state Medicaid agency must be contained in a Medicaid regulation or statute. None of the provisions cited by RCJ is a "limited exception" to a general prohibition against the single state Medicaid agency delegating authority. (See Pet. App. 76-77, 84-85.) These provisions set forth state plan requirements which have nothing to do with 42 U.S.C. §1396a(a)(5) or 42 C.F.R. §431.10(e).

These state plan requirements relate to specific facets of the Medicaid program and are intended to maximize utilization of and coordination of the provision of medical assistance with services administered or supervised by other agencies and to assure that services provided to recipients of medical assistance are of high quality. RCJ incorrectly states that there is a general requirement that "each State Medicaid Plan ... describe the single state Medicaid agency's relations with *other* state and local agencies." (Pet. 4) RCJ erroneously insinuates that a state plan must mention all agencies that perform services, including auditing services, for a state Medicaid agency. RCJ

cites no statute or regulation that contains such a requirement and, indeed, there is none.

Citing 42 U.S.C. §1396a(a)(22) and 42 C.F.R. §431.11(c), RCJ implies that the state plan's organizational description of the single state Medicaid agency must indicate any other agency that performs services for it. (Pet. 4) Neither the statute nor the regulation contains such a requirement. (Pet. App. 77-83)

RCJ erroneously alleges that "[u]nder 42 C.F.R. § 447.45(f), the single state Medicaid agency must conduct the prepayment and postpayment reviews. There is no statute or regulation permitting such postpayment and prepayment reviews to be delegated by the single state Medicaid agency to another agency." (Pet. 4-5) The authorizing statute, 42 U.S.C. §1396a(a)(37), sets forth state plan requirements regarding claims payment procedures and procedures of prepayment and postpayment claims review to ensure the proper and efficient payment of claims and management of the program. (Pet. App. 78) 42 C.F.R. §447.45(f) makes the single state agency responsible for ensuring that prepayment and postpayment claims review covers specific areas. (Pet. App. 85-90) In fact, the prepayment claims review required by 42 C.F.R. §447.45(f)(1) is the type of screening that DHS' fiscal intermediary performs for DHS using its limited editing capabilities. Again, RCJ incorrectly assumes that, because there is no statute or regulation expressly authorizing DHS to delegate this task, any such delegation is prohibited by 42 C.F.R. §431.10(e). (See Pet. App. 4-5)

RCJ incorrectly implies that under 42 U.S.C. §1396a(a)(27) Medicaid providers are not required to agree to furnish records to any other state agency. (Pet. 5) 42 U.S.C. §1396a(a)(27) does not prohibit a state Medicaid agency from designating another state agency which performs audits on its behalf as the agency to which a provider must furnish records. (Pet. App. 77-78)

42 U.S.C. §1396a(a)(42), which RCJ has not mentioned, provides that a state plan for medical assistance must–

> "provide that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be

necessary to insure that proper payments are made under the plan." (App. 79)

RCJ has also failed to mention 42 C.F.R. §§431.107 and 431.108. (App. 80-83) 42 C.F.R. §431.107 sets forth state plan requirements, based on 42 U.S.C. §1396a(a)(27) and other provisions, that relate to the keeping of records and the furnishing of information by all providers of services. This regulation requires the State plan to provide for provider agreements in which the providers must agree to certain requirements related to the keeping of records and the furnishing of information. The States may impose additional requirements for participation in the State's Medicaid program. (See 42 C.F.R. §431.108(b)(2), App. 81-82.)[2/]

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2. 42 C.F.R.§430.0, which sets forth the Medical Assistance Program description, states:

> "Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services." (App. 80)

42 C.F.R. §430.1, which sets forth the Scope of Subchapter C – Medical Assistance Programs, states, in relevant part:

> "The regulations in subchapter C set forth State plan requirements, standards, procedures, and conditions for obtaining Federal financial participation. (F.F.P.)" (App. 80)

The regulations in subchapter C provide the Federal

Lastly, RCJ states:

> "State Plan Amendments must be submitted by the single state agency and approved by U.S. DHHS when there are material changes in the organization or policy of the state Medicaid program. *See* 42 C.F.R. §430.12(c)(1)(ii) [1999]. Appendix at 79." (Pet. 5)

DHS' delegation of audit authority to the State Controller is not a material change in the organization or policy of the state Medicaid agency and does not require a state plan amendment.

STATEMENT OF THE CASE

In accordance with 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10(b)(1), the California Medicaid State Plan under title XIX of the Social Security Act designates the California State Department of Health Services ("DHS") as the single State agency to administer or to supervise the administration of California's State Plan. California's Medicaid program is known as Medi-Cal. (Pet. App. 2-4)

The Health Care Financing Administration ("HCFA"), part of the United States Department of Health and Human Services, is the federal agency responsible for administering the Medicaid program. (Pet. App. 2) HCFA is authorized to make payments to states whose medical assistance plans meet the requirements of the federal statute. (42 U.S.C. §1396) (Pet. App. 3-4)

Postpayment audits of a Medi-Cal provider's claims are required under federal law. (42 U.S.C. §1396a(a)(37); 42 C.F.R. §§447.45(c)(1), 447.45(f), 456.3) (Pet. App. 78, 85-90; App. 83)

On July 1, 1997, DHS and the California State Controller ("SCO" or "Controller")) entered into an interagency agreement "for the purpose

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requirements for a State to obtain FFP. The States are allowed to impose additional requirements for participation in the State's Medicaid program.

of increasing the State's auditing ability to identify and recover California Medical Assistance Program (Medi-Cal Program) overpayments...." The interagency agreement authorized the Controller "to perform audit services relating to the Medi-Cal Program." (Pet. App. 14)

This case arises from a postpayment audit of RCJ's Medi-Cal claims by SCO. Pursuant to California Government Code §§ 925.6, 926.15, and 12410 and pursuant to the July 1, 1997 interagency agreement between SCO and DHS, SCO conducted an audit of RCJ's Medi-Cal claims for medical testing services which were submitted during the period January 9, 1997 through October 9, 1997. The purpose of this review was to determine RCJ's compliance with the applicable provisions of the Medi-Cal program governing the performance of laboratory services. SCO's audit report concluded that RCJ had been overpaid $1,296,801.00 by the Medi-Cal program for the services rendered. SCO conducted a follow-up audit of RCJ's Medi-Cal claims submitted for medical testing services which were performed during the period of October 10, 1997 through March 26, 1998. This audit report concluded that RCJ had been overpaid $164,766.00 by the Medi-Cal program for the services rendered. RCJ appealed from the audit findings of both reports. These two appeals, Appeal Nos. SR8-0298-550-RC and SR8-0398-644-RC, were consolidated for hearing and decision. (See Pet. App. 42-73)[3/]

In its administrative appeal, RCJ argued that the single state agency requirements of federal Medicaid law prohibit the Controller from conducting Medi-Cal audits. (Pet. App. 48-52) Contrary to RCJ's representation, there is no indication that RCJ raised any issue related to the State Medicaid Plan.

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3. A review of medical records and interviews with physicians and patients demonstrated that RCJ billed Medi-Cal for laboratory tests that were not supported by the referring physician's medical records, that were not ordered by the referring physicians, that were not performed, and that were not provided to the beneficiaries indicated on RCJ's laboratory requisition forms. Moreover, there is no indication that relatives of patients were interviewed. (Pet. App. 63-67)

On August 6, 1999, DHS issued its Final Decision in RCJ's audit appeals. DHS determined that the SCO has the authority to audit Medi-Cal providers. (Pet. App. 42-73)

On October 28, 1999, RCJ filed a petition for writ of mandate pursuant to California Code of Civil Procedure §1094.5 ("petition") seeking to set aside DHS' Final Decision issued August 6, 1999. RCJ alleged that the decision was "invalid because the Controller lacks the authority under federal Medicaid law to audit Medi-Cal payments" and "arbitrary and capricious to the extent that it imposes liability for a Medi-Cal overpayment on an independent clinical laboratory when the laboratory performs testing pursuant to an order of a physician, which misidentifies the patient for whom the testing was performed." (App. 7) The only issue raised in the petition and briefed by RCJ was whether the single state agency provisions of 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10(e) prohibit DHS from delegating audit authority to the State Controller. (App. 1-19)

On May 2, 2000, the trial court granted the petition. The Court's minute order dated May 2, 2000 states, in relevant part:

> "The issues in this case are conclusively determined by the Court of Appeal Decision in DOCTOR'S MEDICAL LABORATORY INC. v. CONNELL, 69 Cal.App. 4th 891 (1999), which decision is final and binding upon this court. In its decision the Court of Appeal held that the Controller could not lawfully exercise power to audit payments of Medi-Cal claims submitted by providers like petitioner.
>
> To the extent that respondent's final administrative decision holds that the State Controller has the authority to audit Medi-Cal claims, and insofar as it relies upon said audit for any finding of fact, said decision is inconsistent with the aforesaid decision of the Court of Appeal, respondent has not proceeded in the manner required by law, and its final administrative decision constitutes an abuse of discretion within the meaning of Section 1094.5 of the Code of Civil Procedure." (App. 23-24)

On May 18, 2000, judgment was entered granting a peremptory writ

of mandate. The Judgment Granting Peremptory Writ of Mandate states; in relevant part:

> "IT IS HEREBY ORDERED, ADJUDGED AND DECREED that a peremptory writ of mandate be issued requiring the respondent, the Director of the State Department of Health Services to set aside her Final Decision in this case insofar as it relies upon the audit findings of the State Controller." (App. 27)

On May 19, 2000, a Peremptory Writ of Mandate issued commanding the Director of DHS to "Set aside the Final Decision of the State Department of Health Services in this matter insofar as it relies upon the audit findings of the State Controller." (App. 28)

Accordingly, the sole issue raised and ruled on in the trial court was whether the single state agency provisions of 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10(e) prohibit DHS, the state Medicaid agency in California, from delegating to the State Controller the authority to perform Medi-Cal audits on its behalf.

On July 19, 2000, DHS filed a Notice of Appeal. On appeal, RCJ argued that the single state agency requirement of federal Medicaid law, as set forth in 42 U.S.C. §1396a(a)(5) and its implementing regulation, 42 C.F.R. §431.10(e), prohibits DHS from delegating audit authority to the State Controller. RCJ contended that HCFA's interpretation of the statute and regulation, as demonstrated by its approval of a state plan amendment which reflected the fact that the State Controller performs Medi-Cal audits on behalf of DHS, was entitled to no special deference and, in any event, was immaterial because the Controller audited RCJ before HCFA expressed its approval. (See Pet. App. 1-38)

In its published decision filed August 23, 2001, the Court of Appeal reversed the judgment of the trial court. The Court held that federal Medicaid law, and specifically the single state agency requirement, does not prohibit DHS from delegating to the State Controller's Office the authority to audit Medi-Cal providers. (*RCJ,* Pet. App. 1-38)

The Court held that the language of 42 U.S.C.§1396a(a)(5) plainly

suggests that a state Medicaid may delegate functions such as auditing to another state agency. The Court rejected RCJ's contention that the plain language of 42 C.F.R §431.10(e) prohibited DHS from delegating audit authority to the State Controller and held that HCFA's interpretation of its own regulation, 42 C.F.R.§431.10(e), as allowing DHS' delegation of Medi-Cal audit authority to the State Controller was based on a reasonable construction of the federal statutory single state agency provision and the implementing regulation and entitled to deference. HCFA's interpretation was set forth in a March 24, 1999 letter from Sally Richardson, the Director of HCFA's Center for Medicaid and State Operations, to DHS, which expressed approval of the State Controller's audit authority, and was reflected by HCFA's approval on December 17, 1999 of a state plan amendment which provided, "The State Controller's Office will perform audits of Medi-Cal expenditures on behalf of DHS and will submit its findings and recommendations to DHS for appropriate action." The state plan amendment was approved with an effective date of July 1, 1998, the effective date of the amended interagency agreement in effect at the time of the approval. HCFA's December 17, 1999 letter to DHS, which accompanied a copy of the state plan amendment, stated in relevant part, "[The state plan amendment] amends the State plan to reflect the fact that the State Controller's Office performs audits of Medi-Cal expenditures on behalf of the Department of Health Services. Our review of [the state plan amendment] was conducted in accordance with the requirements of section 1902(a)(5) of the Social Security Act (the Act) and the regulatory provisions at 42 C.F.R. 431.10 and 431.11." (See Pet. App. 1-38.)

The Court rejected RCJ's contention that HCFA's interpretation of 42 C.F.R.§431.10(e), as reflected in the March 24, 1999 Sally Richardson letter and HCFA's December 17, 1999 approval of the state plan amendment effective July 1, 1998, was immaterial because the Controller audited it before HCFA took these actions. The Court concluded that HCFA's interpretation of 42 C.F.R.§431.10(e) was squarely presented since at the time DHS issued its final decision HCFA had by the Richardson letter expressed its opinion that the delegation of audit authority to the Controller was fully compliant with federal single state agency requirements and at the time the trial court issued its writ of mandate HCFA had in addition approved the state plan amendment. (Pet. App. 23)

The significance of the March 24, 1999 Sally Richardson letter and the December 17, 1999 state plan amendment to the Court of Appeal decision is that they are expressions by HCFA of its approval of the State Controller's delegated audit authority and reflect HCFA's interpretation of the single state agency provisions of 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10(e) as not prohibiting DHS from delegating Medi-Cal audit authority to the State Controller. The state plan amendment, as such, was not necessary in order for DHS' contractual delegation of Medi-Cal audit authority to the State Controller to comply with these single state agency provisions. Thus, the effective date of the state plan amendment relative to the audit of RCJ is irrelevant. The single state agency provisions of 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10(e) had not changed and HCFA's expressed interpretation of those provisions as not prohibiting DHS' delegation of Medi-Cal audit authority to the State Controller applies regardless of when the audit of RCJ was performed. DHS had the authority to delegate Medi-Cal audit authority to the State Controller, which it did contractually through an interagency agreement. The state plan amendment was not necessary to "give" DHS the authority to delegate Medi-Cal audit authority to the State Controller.

On August 28, 2001, RCJ filed a petition for rehearing in the Court of Appeal, which was denied on August 30, 2001. (Pet. App. 39)

On September 18, 2001, RCJ filed a petition for review in the California Supreme Court, which was denied on December 12, 2001. (Pet. App. 75; App. 61-62)

The Court of Appeal issued its remittitur on December 28, 2001. (Pet. App. 74)

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RCJ'S STATEMENT OF THE CASE FAILS TO COMPLY WITH RULE 14(1)(g)(i) AND IS MISLEADING

RCJ's Statement of the Case fails to comply with Rule 14(1)(g)(i). RCJ fails to specify the stage in the proceedings, both in the court of first instance and the appellate courts, when the federal questions it seeks

review of were raised; the method or manner in raising them and the way in which they were passed on by those courts; and pertinent quotations of specific portions of the record or summary thereof, with specific reference to the places in the record where the matter appears, so as to show that the federal question was timely and properly raised and that this Court has jurisdiction to review the judgment on a writ of certiorari.

Furthermore, RCJ makes a number of misleading statements as to the Court of Appeal decision in *RCJ*. (Pet. App. 9-10) RCJ states:

> "The California Court of Appeal contended it did not have to follow the previous decision of the Court in *Doctor's* because *Doctor's* had been issued before State DHS had submitted and the federal government had approved the December 17,1999 State Plan Amendment describing for the first time in the Plan the Controller's role in auditing Medi-Cal providers. Appendix at 21-23. [¶] In its August 23, 2001 decision, the Court of Appeal concluded that U.S. DHHS' approval of the December 17, 1999, State Plan Amendment constituted that agency's interpretation of the governing federal Medicaid regulations and statutes. And, according to the California Court of Appeal, even though the federal Medicaid regulation at issue, 42 C.F.R. §431.10(e) (which had not changed since *Doctor's* was decided), expressly prohibits the delegation of administrative discretion by the single state Medicaid agency to another state agency, the federal government's approval of the State Plan Amendment was reasonable and entitled to controlling deference. [¶] ... the California Court of Appeal relied heavily on the December 17, 1999, State Plan Amendment to distinguish its holding in RCJ's case from its previous holding in *Doctor's* and to permit State DHS to delegate authority to the State Controller, ..." (Pet. 9)

The Court of Appeal disagreed with RCJ's contention that *Doctor's Medical Laboratory, Inc. v. Connell* (1999) 69 Cal.App.4th 891 ("*Doctor's I*") controlled the resolution of this case, explaining that *Doctor's* was filed on February 1, 1999, before HCFA expressed its approval of DHS' delegation of audit authority to the State Controller

and its opinion that the delegation was fully compliant with federal single state agency requirements in the March 24, 1999 Sally Richardson and by virtue of its approval on December 17, 1999 of a state plan amendment reflecting the fact that the SCO performs audits of Medi-Cal expenditures on behalf of DHS. (Pet. App.22) The Court of Appeal relied on the state plan amendment and the Richardson letter as expressions of HCFA's interpretation of the federal single state agency provisions as not prohibiting DHS from delegating audit authority to the State Controller; the Court did not rely on the state plan amendment "to permit State DHS to delegate authority to the State Controller." (Pet. App. 1-39)

The Court of Appeal also rejected RCJ's contention that the plain language and "obvious" meaning of 42 U.S.C. §1396a(a)(5) and its implementing regulation, 42 C.F.R. §431.10(e), prohibit DHS from delegating audit authority to the State Controller. The Court found that, although Congress did not address the precise question at issue, the statutory language plainly suggests that a state Medicaid agency may delegate functions to another state agency. The Court of Appeal further found that HCFA's construction of the federal statutory single state agency requirement in 42 C.F.R. §431.10(e) is a permissible and reasonable one and that HCFA's construction of 42 C.F.R. §431.10(e) as reflected in Ms. Richardson's March 24, 1999 letter and the December 17, 1999 approval of the state plan amendment as allowing DHS to delegate audit responsibility to the State Controller is entitled to deference. The Court observed that HCFA has, from the inception of Medicaid, interpreted the regulation as allowing a single state Medicaid agency to delegate responsibilities to another state agency. The Court had before it the history of, and case law discussing, the single state agency requirements, which were absent in the *Doctor's I* case. (Pet. App. 1-39; App 50-58)

RCJ further alleges:

> "Although the California Court of Appeal relied heavily on the December 17, 1999, State Plan Amendment to distinguish its holding in RCJ's case from its previous holding in *Doctor's* and to permit State DHS to delegate authority to the State Controller, the Court disregarded the legal impact of the Plan Amendment's July 1, 1998, effective date. Thus even

> though the State Controller audited RCJ while the State Plan indicated that only State DHS did so and well before July 1, 1998, the effective date of the Plan Amendment, the Court seemingly allowed the Plan Amendment to be applied to RCJ (without expressly deciding the issue of the legal impact of the plan amendment's effective date). Appendix at 23." (Pet. 9-10)

The Court of Appeal addressed and rejected RCJ's contention that HCFA's action was immaterial because the Controller audited it *before* HCFA expressed its approval. (Pet. App. 23) As set forth above, the Court of Appeal relied on the state plan amendment and the Richardson letter as expressions of HCFA's interpretation of the federal single state agency provisions as not prohibiting DHS from delegating audit authority to the State Controller. (Pet. App. 22) The Court did not rely on the state plan amendment "to permit State DHS to delegate authority to the State Controller," as RCJ misrepresents. The state plan amendment, which merely reflects the fact that the State Controller audits Medi-Cal expenditures on behalf of DHS, was unnecessary in order for DHS to permissibly delegate audit authority to the State Controller and, therefore, its effective date is irrelevant. The fact that the State Controller's audit of RCJ took place before the effective date of the state plan amendment has no legal impact. The provisions of 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10(e) were the same at the time of RCJ's audit as they were when HCFA expressed its interpretation of these provisions through Ms. Richardson's March 24, 1999 letter and HCFA's December 17, 1999 approval of the state plan amendment.

NEITHER OF THE TWO QUESTIONS PRESENTED IN THE PETITION WAS PROPERLY RAISED AND DECIDED BELOW

Both of the questions presented by RCJ incorrectly suggest that the significance of the state plan amendment to the Court of Appeal decision in *RCJ* was that it authorized DHS to delegate to the State Controller the authority to perform Medi-Cal audits. The questions erroneously suggest that the Court of Appeal based its decision on the fact that HCFA had approved a state plan amendment which purportedly

allowed DHS to delegate audit authority to the State Controller. This, in turn, incorrectly suggests that the effective date of the state plan amendment is significant to the Court's decision. In fact, the Court of Appeal decision was based on deference given to HCFA's interpretation of 42 C.F.R.§431.10(e) as allowing DHS to delegate Medi-Cal audit authority to the State Controller, which interpretation was expressed by means of the Sally Richardson letter and the state plan amendment. The significance of the state plan amendment, as well as the earlier Richardson letter, to the Court of Appeal's decision was that it indicated HCFA's interpretation that 42 U.S.C.§1396a(a)(5) and 42 C.F.R.§431.10(e) do not prohibit DHS from delegating Medi-Cal audit authority to the State Controller.

RCJ is improperly attempting to get this Court to decide the question, totally separate from the issue of the single state agency requirements of 42 U.S.C.§1396a(a)(5) and 42 C.F.R. §431.10(e), of whether delegation of Medicaid audit authority by a state Medicaid agency is invalid in the absence of a state plan provision.

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PETITIONER'S "SUMMARY OF WHY THE AUGUST 23, 2001 DECISION IS WRONG" IS ERRONEOUS

RCJ contends that the plain language of 42 C.F.R.§431.10(e) prohibits DHS from delegating audit authority to the State Controller, that such a delegation of audit authority is an exception to "the general regulatory prohibition of 42 C.F.R.§431.10(e)" and would require a federal statute or regulation "expressly [permitting] a single state Medicaid agency to delegate such authority to another agency," and that under 42 U.S.C.§1396a(a)(37) and 42 C.F.R.§447.45(f) only the single state Medicaid agencies are authorized to perform postpayment reviews. Therefore, according to RCJ, the California Court of Appeal should not have considered HCFA's interpretation of its own regulation as allowing DHS to delegate audit authority to the State Controller and should not have considered the legislative and regulatory history of 42 U.S.C.§1396a(a)(5) and 42 C.F.R.§431.10(e). RCJ further contends that, in any event, the State Controller's audit of RCJ was invalid because at the time the audit was performed California's State Plan did

not indicate that the State Controller performs Medi-Cal audits on behalf of DHS, purportedly in violation of 42 U.S.C.§431.11(c). (Pet. 10-11)

RCJ's basic assumption and bald assertion that the plain language 42 C.F.R.§431.10(e) prohibits DHS from delegating audit authority to the State Controller is erroneous. Both the California Court of Appeal in *RCJ* and the United States Court of Appeals for the Ninth Circuit in *San Lazaro* (9th Cir. 2002) 278 F.3d 932, rehg. den. and sub. opn. (9th Cir.(Cal.)) 2002 WL 571674, filed April 17, 2002 , have exhaustively reviewed the language and the history of 42 U.S.C. §1396a(a)(5) and 42 C.F.R.§431.10(e) and have correctly concluded that neither the statute nor the implementing regulation prohibits DHS from delegating audit authority to the State Controller. (See Pet. App. 1-39.) RCJ has no authority whatsoever for its contention that a federal statute or regulation must expressly permit a single state Medicaid agency to delegate audit authority to another state agency. Moreover, 42 U.S.C.§1396a(a)(37) and 42 C.F.R.§447.45(f) do nøt prohibit a single state Medicaid agency from delegating audit authority to the State Controller. 42 U.S.C.§1396a(a)(37) sets forth state plan requirements regarding claims payment procedures and procedures of prepayment and postpayment claims review to ensure the proper and efficient payment of claims and management of the program. 42 C.F.R.§447.45(f) sets forth requirements that the prepayment and postpayment review must meet.

Furthermore, the State Controller's audit of RCJ was not void because at the time of the audit the state plan may not have indicated that the State Controller performs Medi-Cal audits on behalf of DHS, allegedly in violation of 42 U.S.C.§1396a(a)(22) and 42 C.F.R §431.11(c). 42U.S.C. §1396a(a)(22) provides, in relevant part, that a state plan must "include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have...." Its implementing regulation, 42 C.F.R§431.11, "prescribes the general organization and staffing requirements for the Medicaid agency and the State plan." 42 C.F.R. §431.11(c) requires that the State plan include "(i) A description of the organization and functions <u>of the Medicaid agency</u> and an organization chart; (ii) A description of the organization and functions of the medical assistance unit and an organization chart; and (iii) A description of the kinds and number of professional medical personnel and supporting staff used in the

administration of the plan and their responsibilities." (Emphasis added.) 42 U.S.C. §1396a(a)(22) and 42 C.F.R. §431.11 do not require that any agency that performs audit services for the single state Medicaid agency be mentioned in the state plan in the organizational description of the Medicaid agency or elsewhere. Nor does any other statutory provision or regulation contain such a requirement.

Moreover, RCJ's petition for writ of mandate and its memorandum of points and authorities in support of its motion for peremptory writ of mandate in the trial court did not raise this issue. RCJ's pleadings below never mentioned 42 U.S.C.§1396a(a)(22). The first time RCJ mentioned 42 C.F.R.§431.11(c) below was in its respondent's brief in the Court of Appeal in a section entitled "D. THE FEDERAL MEDICAID SINGLE STATE AGENCY REQUIREMENTS FOR AUDITING AND REVIEWING MEDICAID CLAIMS AND PAYMENTS," in which RCJ states: "Additionally, the State Medicaid Plan must also contain a description of the organization and function of the single state Medicaid agency and its personnel. 42 C.F.R.§431.11(c)(i) [1999]. The single state Medicaid agency must further include a description of the kind and number of professional medical personnel to be used in administering the plan." No mention was made of 42 C.F.R.§431.11(c) in any of the arguments in respondent's brief. RCJ did not mention 42 C.F.R. §431.11(c) in its petition for rehearing, and the only place in its petition for review in the California Supreme Court where RCJ mentioned the 42 C.F.R.§431.11(c) was in its Statement of the Case, where RCJ basically repeated what it had said in its respondent's brief in the Court of Appeal.

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RCJ HAS PROVIDED NO COMPELLING REASON FOR GRANTING A WRIT OF CERTIORARI

Rule 10 of the Court provides, in relevant part, "Review on a writ of certiorari is not a matter of right, but of judicial discretion. A petition for a writ of certiorari will be granted only for compelling reasons." There is no compelling reason for this High Court to grant review in this case. This case does not provide any of the reasons the Court considers under Rule 10, nor does it provide any other compelling reason for

granting RCJ's petition for writ of certiorari.

A. THE DECISION OF THE CALIFORNIA COURT OF APPEAL IN *RCJ* DOES NOT CONFLICT DIRECTLY WITH ITS DECISION IN *DOCTOR'S I* AND, EVEN ASSUMING ARGUENDO THAT THERE WAS A CONFLICT, THAT WOULD NOT PROVIDE A COMPELLING REASON FOR GRANTING THE WRIT

In November 1997, Doctor's Medical Laboratory, Inc. ("DML") filed a petition for writ of mandate compelling the State Controller to pay DML approximately $3 million allegedly earned and owed for services to Medi-Cal patients. DML alleged that in September 1997, without notice to DML, the Controller commenced withholding payments due DML and already approved for payment by EDS. DML further alleged that the Controller's audit and withholding of Medi-Cal payments violated the single state agency provisions of Medicaid law, specifically, 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10(e). (Pet. App. 99-107)

The trial court rejected DML's contention that the single state agency provisions of federal Medicaid law prohibited the State Controller from auditing Medi-Cal claims and payments.[4/] The court's minute order for January 12, 1998 states:

> "Petitioner is not correct in its contention that the Controller has no right to audit petitioner's claims. There is no state or federal law that prohibits the Controller from doing so. The fact that an audit is performed by another state agency does not prohibit the Controller from further checking to see whether that agency is adequately performing its duties.
>
> The issue in this case is NOT whether the Controller can lawfully audit petitioner's claims, but rather whether the Controller can lawfully withhold payment from petitioner for as long as she chooses to take to complete such an audit."

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4. Los Angeles County Superior Court Judge David P. Yaffe was the trial judge herein and in *Doctor's I.*

(App. 43-44)

As to the SCO withhold, the court ruled that under Government Code §926.15(a) the Controller could withhold Medi-Cal payments approved by DHS' fiscal intermediary, EDS, for up to 30 days to determine the amount she finds due and pay it. The Court stated:

> "The Controller may deduct from any such payment any part of such claim she finds to be incorrect plus any amount she determines petitioner has been overpaid on prior claims." (App. 46)

Judgment was entered January 29, 1998. The Judgment denied DML's request for injunctive relief prohibiting the State Controller from auditing or reviewing the Medi-Cal claims submitted to, and approved for payment by, the Medi-Cal fiscal intermediary and continuing to withhold the sums at issue. The Judgment granted DML's request for mandate relief to the extent that "the Controller must determine the amount due for any Medi-Cal claims submitted by Doctor's, including those previously approved for payment by the Department of Health Services;" and, "[i]f the Controller does not issue such determination within thirty days after receipt of a claim approved by the D.H. [sic], all claims which have been submitted for payment more than thirty days from the date of this judgment shall be immediately payable and must be released immediately to Doctor's." Except to the extent set forth above, DML's request for mandate relief was denied. (App. 48-49)

Both sides appealed from the judgment. (*Doctor's I*, 69 Cal.App.4th at p.895; Pet. App.103)

In its decision filed February 1, 1999, the Court of Appeal modified the judgment of the trial court "to require Controller to forthwith pay to Doctor's all amounts approved for payment by the Department of Health Service's fiscal intermediary, EDS. As so modified, the judgment [was] affirmed." (*Doctor's I*, at p. 898; Pet. App. 107)

Thus, in *Doctor's I* both the trial court and the Court of Appeal refused to prohibit the State Controller from auditing the Medi-Cal claims and payments of DML. DHS, which was not a party to the action, was not prohibited from collecting an overpayment based on

SCO's audit findings. The Court of Appeal only modified the trial court's judgment to the extent of requiring the Controller to release her withhold on Medi-Cal payments to DML.

In *Doctor's I*, the Court of Appeal based its decision requiring the Controller to release DML's Medi-Cal payments which had been approved by EDS on its determination that the 1997 Interagency Agreement ("IA") authorized the Controller to "take corrective action", including the "authority to change or disapprove prior decisions by DHS' agent (EDS) to pay provider claims." The Court concluded, "This transfer of authority from DHS to the Controller violated the federal statutory and regulatory bar on delegation by the 'single designated agency' of discretionary authority. It improperly empowered the Controller to 'change or disapprove' administrative decisions by DHS and its agent." (*Doctor's Medical Laboratory, Inc. v. Connell*, 69 Cal.App.4th 891, 897; Pet. App.105).

The Court's decision was based on a number of erroneous assumptions. First, the 1997 IA did not authorize the Controller to "take corrective action," which the Court presumed meant "withholding sums believed to constitute overpayment." (Pet. App. 102, 105) Nowhere does the 1997 Interagency Agreement authorize the Controller to "take corrective action." (See DHS' Motion for Judicial Notice, Exhibit H, in Court of Appeal.) The agreement explicitly provided, in relevant part:

> "5. As a representative of DHS, SCO will not initiate a withhold of a provider's reimbursement in the amount identified by the audit.
>
> 6. However, if SCO initiates a withhold under its own authority, SCO will not issue notices of withhold with the audit report and demand notice...."

Thus, the 1997 IA, in fact, prohibited the Controller from withholding Medi-Cal payments as DHS' representative, but recognized that the Controller might initiate a withhold under her own authority pursuant to state law.

Second, the Court's assumption that the Controller's withhold changed or disapproved an administrative decision by DHS within the

meaning of 42 C.F.R. §431.10(e)(3) is incorrect. (Pet. App. 105) EDS' "approval" of a claim is not an "administrative decision" of DHS within the meaning of 42 C.F.R. §431.10(e)(3). EDS is a fiscal intermediary, i.e. claims processor, for DHS. EDS utilizes a mechanized claims processing system with a limited edit capability for screening improper claims. The fact that EDS has cleared a claim for payment does not mean that the claim has a final approval by DHS. (Declaration of James R. Dandridge, Clerk's Transcript on Appeal, 198-201, ¶17, App. 21-22)

Third, 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10(b)(1) require that the state Medicaid plan designate a single State agency "to administer or supervise the administration of the plan." (Emphasis added.) The single state agency provisions of 42 C.F.R. §431.10 do not prohibit DHS from delegating any discretionary authority whatsoever in the administration of the Medi-Cal plan. "Administrative discretion" in the administration of the plan does not mean "any discretion" in administering the plan.

Fourth, the Court's assumption that prior to mid-1997 the Controller did not perform Medi-Cal audits and the Controller's activities with respect to Medi-Cal claims and payments were "limited to issuing checks, a nondiscretionary activity" is incorrect. (Pet. App. 102) SCO has been auditing Medi-Cal claims and payments since at least 1979.

Fifth, the Court's assumption that "[t]he interagency agreement's recitation that 'DHS will review all reports of overpayments identified by [Controller] for policy and/or procedural implications' does not save the delegation of authority from violating federal law" is incorrect. (*Id.*, at p. 897) This ensures that, in conducting Medi- Cal audits on behalf of DHS, SCO will not substitute its judgment for that of DHS with respect to the application of Medi-Cal policies, rules, and regulations issued by DHS. Furthermore, SCO does not have the authority to change or disapprove any administrative decision of DHS and has not done so. Administrative appeals of audit determinations are held before Administrative Law Judges of DHS' Office of Administrative Hearings and Appeals and the Director of DHS issues the final decision. The prohibition against delegation of authority is a ban against the single State agency delegating its ultimate authority for exercising administrative judgment in the statewide administration of the plan.

DHS has not delegated any of its ultimate authority in this regard. As the single State agency, DHS is ultimately responsible for services such as auditing services performed by other agencies under the plan and for assuring that the services meet federal requirements; however, this does not mean that DHS has to take over or direct such services. Additionally, of particular significance to this case and others where Medi-Cal audits have been performed by SCO, the provision for a single State agency is not designed to set aside the relationship with state officers such as the Controller, the single state agency is still subject to the normal budget and audit procedures in the state, and SCO may perform services for the single State agency that are essential to the operation of the plan. (Pet. App. 1-39; App. 50-58)

Significantly, in *Doctor's I* the Court of Appeal observed, "Neither side has cited legislative history or case law discussing the legislative and regulatory reasons for the single agency and nondelegation rules." (Pet. App. 106) Thus, the record in *Doctor's I,* in which the Director of the California Department of Health Services was not a party was not fully developed in areas very critical to the issues in *Doctor's I* and *RCJ.*

In contrast to *Doctor's I*, the authority of the Controller to withhold Medi-Cal payments was not at issue in *RCJ.* The issue in *RCJ* was whether the single state agency provisions of federal Medicaid law, specifically 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10(e), prohibit the Controller from conducting Medi-Cal audits and prohibit DHS from basing an overpayment determination on SCO's audit findings. *Doctor's I* did not prohibit the Controller from conducting Medi-Cal audits. In *RCJ*, the petitioner did not even contest the audit findings and its overpayment determination.

Accordingly, *RCJ* does not directly conflict with *Doctor's I.* Any discussion in *Doctor's I* of whether the single state agency provisions 42 U.S.C.§1396a(a)(5) and 42 C.F.R.§431.10(e) prohibit DHS from delegating audit authority to the State Controller is at most dicta. Moreover, the Court of Appeal in *Doctor's I* did not have before it the statutory and regulatory history of, case law regarding, or HCFA's interpretation of these provisions, as did the Court of Appeal and the California Supreme Court in *RCJ*, in which the Director of the State Department of Health Services was the respondent. Furthermore, in *Doctor's Medical Laboratory, Inc. v. The Director of the State*

Department of Health Services, California Court of Appeal, Second Appellate District Case No. B142529 ("*Doctor's II*"), a case virtually identical to *RCJ*, the Court rejected the provider's claim that DHS' final administrative decision had to be set aside because the Controller performed the audit. (App. 77-78) Doctor's Medical Laboratory, Inc. has filed a petition for review in the California Supreme Court, raising the same arguments which that Court previously rejected in *RCJ*.

Moreover, even assuming arguendo that there were a conflict between *Doctor's I* and *RCJ*, the criteria of Rule 10(b) are not met. Rule 10(b) refers to the situation in which the state court of last resort of one state has decided an important federal question in a way that conflicts with the decision of the state court of last resort of another state. The state court of last resort in California is the California Supreme Court. Neither *Doctor's I* nor *RCJ* is a decision by California's court of last resort. Furthermore, even if both decisions were from the California Supreme Court, they would both be from the same state court of last resort, which would not meet the criteria of Rule 10(b). In the case of *RCJ*, the California Supreme Court correctly determined that RCJ did not create a conflict in the law. Moreover, *RCJ* is fully consistent with the decision of the Ninth Circuit Court of Appeals in *San Lazaro*.

B. THE DECISION OF THE CALIFORNIA COURT OF APPEAL IN *RCJ* DOES NOT CONFLICT WITH DECISIONS OF THE UNITED STATES COURT OF APPEALS OR THE CALIFORNIA COURT OF APPEAL REGARDING THE DEFERENCE TO BE GIVEN ADMINISTRATIVE AGENCIES' INTERPRETATIONS OR REGARDING THE ISSUE OF THE EFFECTIVE DATE OF THE STATEMENT PLAN AMENDMENT

RCJ alleges, as a second reason for this Court to grant a writ of certiorari, that the decision of the California Court of Appeal "indirectly conflicts" with decisions of the United States Court of Appeals and the California Court of Appeal regarding the deference to be given administrative agencies' interpretations and regarding the issue of the effective date of Medicaid state plan amendments. As set forth below, no such "indirect conflict" exists. Furthermore, this reason does not meet the criteria of Rule 10(b) and, even assuming arguendo that there

were an indirect conflict, such an indirect conflict would not warrant the granting of RCJ's petition.

Moreover, RCJ has failed to mention that *RCJ* is entirely consistent with the Ninth Circuit Court of Appeals' decision in *San Lazaro* (9th Cir. 2002) 278 F.3d 932, rehg. den. and sub. opn. (9th Cir.(Cal.)) 2002 WL 571674 ("*San Lazaro*"), which specifically addresses 42 U.S.C. §1396a(a)(5) and 42 C.F.R §431.10(e) and cites *RCJ*, with approval, as having "reached" the same conclusion in an unrelated case involving the review of an administrative determination by DHS based on the Controller's finding of an overpayment to a Medi-Cal provider. (*San Lazaro*, *supra* 2002 WL at p.7, fn. 10.) The same arguments made by RCJ herein were made by the plaintiffs in *San Lazaro* and rejected by the Ninth Circuit Court of Appeals. In its published order denying the plaintiffs' petition for rehearing filed April 17, 2002, the Court states:

> "The panel has unanimously voted to deny the petition for rehearing. The full court has been advised of the petition for rehearing en banc, and no active judge of the court has requested a vote on the petition for rehearing en banc. Fed. R. App. P. 35(b). The petition for rehearing is denied and the petition for rehearing en banc is denied."

RCJ makes the bald assertion that the plain language of 42 C.F.R. §431.10(e), which provides in part that the single state Medicaid agency "must not delegate to other than its own officials, authority to...exercise administrative discretion in the administration or supervision of the plan," prohibits DHS from delegating to the State Controller the authority to perform Medi-Cal audits on its behalf. RCJ ignores the rest of the regulation and, based on this false assumption, argues that the Court of Appeal erred in considering the legislative and regulatory history of 42 U.S.C. §1396a(a)(5) and its implementing regulation, 42 C.F.R. §431.10(e), and in giving deference to HCFA's interpretation of the regulation.

42 C.F.R. §431.10(e), which sets forth the requirements for an agency to qualify as the Medicaid agency, provides as follows:

> "(e) *Authority of the single State agency.* In order for an agency to qualify as the Medicaid agency-

(1) The agency must not delegate, to other than its own officials, authority to-

(i) Exercise administrative discretion in the administration or supervision of the plan, or

(ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency." (Pet. App. 82)

42 C.F.R. §431.10(e) is contained in Subchapter C - Medical Assistance Programs. "The regulations in Subchapter C set forth State plan requirements, standards, procedures, and conditions for obtaining Federal financial participation. (F.F.P.)" (42 C.F.R. §430.1, App. 80)

The Court of Appeal decision in *RCJ* thoroughly analyzes the language of both the federal statute, 42 U.S.C. §1396a(a)(5), and the implementing regulation, 42 C.F.R. §431.10(e). The Court correctly concluded that, although the statute does not specifically address the question of whether a State Medicaid agency can delegate audit responsibility to another State agency, the statutory language does plainly suggest that a State Medicaid agency may delegate functions to another State agency. (Pet. App. 23-29) In examining the regulation, the Court of Appeal applied the standards set forth by this High Court and correctly determined that HCFA's interpretation of 42 C.F.R. §431.10(e) as allowing DHS to delegate audit authority to the State Controller is not plainly erroneous or inconsistent with the regulation and, therefore, is entitled to deference. (Pet. App. 29-38) The Court stated:

"...the current single state agency regulation (42 C.F.R. §431.10(e) (2000)) states that the state Medicaid agency may rely on other state agencies' services provided that it does not

delegate *its* authority, i.e., its ultimate authority: to '[e]xercise administrative discretion in the administration or supervision of the plan'; or to '[i]ssue policies, rules, and regulations on program matters.' (42 C.F.R. §431.10(e)(1)(ii) (2000)). In addition, title 42 Code of Federal Regulations, part 431.10(e)(2) (2000)) states, 'The authority of the [state Medicaid] agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.' Another state entity performing services for the state Medicaid agency must not have the authority: 'to change or disapprove' the state Medicaid agency's administrative decisions. (42 C.F.R. §431.10(e)(3) (2000).) Further, the other entity must not have the authority to substitute its judgment for that of the state Medicaid agency 'with respect to the application of policies, rules, and regulations issued by the Medicaid agency.' (*Ibid.*)

Moreover, it is undisputed the DHS has not delegated to the Controller any authority to issue policies, rules, or regulations on Medi-Cal program matters. Nor do we find that the Controller reviews or takes similar action with respect to the DHS's rules, regulations, or decisions. Further, RCJ has not pointed to, and we have not found, *any* evidence in the record that the Controller has been given authority to change or disapprove any administrative decision by the DHS. Instead, the Controller undertakes, on DHS's behalf, required postpayment reviews of provider claims. RCJ also has not pointed to, and we have not found, *any* evidence in the record that the Controller's office has the authority to substitute its judgment for that of the DHS with respect to the application of policies, rules, and regulations issued by the DHS. Nor has the DHS delegated to the Controller any authority to exercise discretion in the administration or supervision of the statewide Medicaid plan. The interagency agreement does not have any bearing on the ultimate authority of the DHS to exercise administrative judgment in the statewide administration or supervision of the Medi-Cal program as conducted under the state plan. What the DHS *has* delegated to the Controller is only the authority to conduct postpayment audits of Medi-Cal

provider claims." (Pet. App. 36-38; see App. 50-58.)

RCJ's basic assumption that the plain language of 42 C.F.R. §431.10(e) prohibits DHS from delegating audit authority to the State Controller is flatly erroneous. Accordingly, *RCJ* does not conflict with any of the United States Court of Appeals or the California Court of Appeal cases cited by RCJ.[5/] Further, as HCFA and the Court of Appeal agreed, a regulation expressly authorizing a state Medicaid agency to delegate audit authority to another state agency is not required. Moreover, 42 U.S.C. §1396a(a)(37) and its implementing regulation 42 C.F.R. §447.45(f) make the state Medicaid agency ultimately responsible for ensuring that prepayment and postpayment claims reviews are conducted. There is nothing that prohibits the state Medicaid agency from delegating this task to another agency. In fact, the prepayment claims review required by 42 C.F.R. §447.45(f)(1) is the type of screening that DHS' fiscal intermediary performs for DHS using its limited editing capabilities.

Nor does *RCJ* conflict with any of the cases cited by RCJ as "prohibiting Medicaid actions which are not authorized by the Medicaid State Plan." RCJ's citation of *Exeter Memorial Hospital Association v. Belshe*, 943 F.Supp. 1239, 1240 (E.D. Cal. 1996), *aff'd*, 145 F.3d 1106, 1109 (9th Cir. 1998), *Oregon Association of Homes v. State Department of Human Resources*, 5 F.3d 1239 (9th Cir. 1993), *Washington State Health Facilities v. State of Washington*, 698 F2d 964 (9th Cir. 1982) and *Washington State Health Facilities v. DSHS*, 879 F.2d 677 (9th Cir. 1980) for the foregoing broad proposition is misleading. All of these

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5. Moreover, in *Wileman Bros. & Elliott, Inc. v. Giannini* (9th Cir. 1990) 909 F.2d 332, the Court stated: "'The language of a regulation or statute is the starting point for its interpretation. [] The plain meaning governs unless a clearly expressed legislative intent is to the contrary, [] or unless such plain meaning would lead to absurd results.' *Dyer v. United States* 832 F.2d 1062, 1066 (9th Cir. 1987)." Thus, even assuming arguendo that the plain language of 42 C.F.R. §431.10(e) prohibited the Controller from auditing, such a meaning would not govern here since there is a clearly expressed legislative and regulatory intent to the contrary and, further, such meaning would lead to absurd results.

cases deal with the requirements of 42 C.F.R. §447.250 *et seq.* related to payment for inpatient hospital and long term care facility services. 42 C.F.R. §447.252(b) requires that the state Medicaid plan specify the methods and standards used to set payment rates. 42 C.F.R. §447.253(a) requires that amendments changing payment methods and standards require HCFA approval. While 42 C.F.R. §430.12(c) provides generally that plans must be amended, and the amendment submitted for HCFA approval, only for material changes in state law or operation of the plan, 42 C.F.R. §447.253(b) provides for submission for HCFA approval of all amendments to methods and standards for payment rates and does not contain a materiality requirement. Unlike 42 C.F.R. §447.250 *et seq.*, there is no statutory or regulatory requirement that a state Medicaid agency obtain HCFA approval of a Medicaid state plan amendment in order to delegate authority to another state agency to perform services such as auditing on behalf of the state Medicaid agency. Nor does such a delegation constitute a "material change" in state law or operation of the plan.

Similarly, *Bingham v. Obledo*, (1983) 147 Cal.App.3d. 401 involves a federal regulation that specifically requires that the state Medicaid plan specify that the Medicaid agency will assure necessary transportation for recipients and describe the methods to be used. 42 C.F.R. §431.53 requires that the state plan "specify that the Medicaid agency will assure necessary transportation for recipients to and from providers" and "[d]escribe the methods that will be used to meet this requirement." The underlying issue in the case was "whether the State is required to have a written plan that (1) specifies that its Medicaid agency will assure necessary transportation for Medi-Cal recipients to and from health providers, and (2) describes the methods that will be used to meet this requirement." (*Id.*, at 403) As set forth above, there is no statutory or regulatory requirement that a state Medicaid agency obtain HCFA approval of a Medicaid state plan amendment in order to delegate authority to another state agency to perform services such as auditing on behalf of the state Medicaid agency.

C. THE FEDERAL QUESTIONS HAVE BEEN FULLY AND PROPERLY RESOLVED AND THERE IS NO CONFLICT WARRANTING THIS COURT'S REVIEW

As set forth above, the federal questions have been fully and properly resolved and there is no conflict warranting this Court's review. RCJ's primary argument for contending that the federal questions involved should be resolved by this Court is that DHS, the State Controller, and the U.S. DHHS have previously emphasized the importance of resolving the issue of whether the single state agency provisions of federal Medicaid law, 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10(e), prohibit DHS from delegating audit authority to the State Controller. The lower court decisions in *Doctor's I* and *San Lazaro,* which were not well-reasoned and which were based on an incorrect view of the law, created confusion over the authority of the State Controller to perform Medi-Cal audits. Medi-Cal providers were filing lawsuits in which they contended that, because 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10(e) prohibited DHS from delegating audit authority to the State Controller, (1) a withhold imposed on Medi-Cal payments pursuant to 42 C.F.R. §455.23, based on the receipt of reliable evidence of fraud or willful misrepresentation by the provider, was invalid if that evidence resulted from an audit by the State Controller, and (2) any overpayment determination by DHS based on a Controller audit was unlawful. The confusion that was created was highly disruptive to the operation of the Medicaid program in California.

The decisions in *RCJ* and *San Lazaro* have fully and properly resolved the legal issues in these cases. There is no remaining conflict in the state or federal decisions that would warrant review by this Court.

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CONCLUSION

The California Court of Appeals decision in *RCJ* correctly resolves the legal issues therein and is fully supported by the Ninth Circuit Court of Appeals decision in *San Lazaro* on these issues. There is no conflict in state or federal decisions on the federal questions involved herein that would warrant this Court's review. Accordingly, respondent, the Director of the California Department of Health Services, respectfully requests that this High Court deny RCJ's petition for writ of certiorari.

DATED: April 25, 2002

Respectfully submitted,

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APPENDIX

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SUPERIOR COURT OF THE STATE OF CALIFORNIA
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RCJ MEDICAL SERVICES, INC., DBA AMERICAN NETWORK LABORATORY, Petitioner, v. THE DIRECTOR OF THE CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES, Respondent.	) Case No. BS060056)) PETITION FOR) WRIT OF) MANDATE)))))

Petitioner, RCJ Medical Services, Inc., doing business as American Network Laboratory ("ANL"), petitioners this Court for a Writ of Mandate under Code of Civil Procedure Section 1094.5, directed to respondent, the Director of the State Department of Health Service ("DHS"), and by this verified Petition alleges as follows:

INTRODUCTION

1. By this action, ANL seeks to set aside a final decision of the Director of DHS refusing to abide by the final decision of the Court of Appeal in the case of Doctor's Medical Laboratory, Inc. v. Connell (1999), 69 CalApp.4th 891. In Doctor's, the Court of Appeal concluded that the State Controller was prohibited by federal Medicaid law from auditing Medi-Cal payments to providers of Medi-Cal services, including independent clinical laboratories, such as ANL. notwithstanding this binding precedent, the Director of DHS has allowed the State Controller to conduct a Medi-Cal audit of ANL and has upheld certain of the audit findings of the State Controller. In addition to seeking an order of this Court setting aside the decision of the Director of DHS, ANL is also requesting an award of attorneys fees because of the clearly arbitrary and capricious nature of the action by the Director of DHS.

THE PARTIES

2. At all times relevant herein, ANL was certified by the Medi-Cal program to furnish laboratory testing services to Medi-Cal patients. ANL provided such laboratory services in Huntington Park, California.

3. Under federal law, DHS is the single state Medicaid agency charged with administering the Medicaid program in California, known as "Medi-Cal." The Director is the Chief Executive Officer of the Department. See generally Welf. & Inst. Code §§ 14000 et seq. and 22 C.C.R. §§ 50,000 et seq.

THE FEDERAL MEDICAID REQUIREMENTS

4. Medicaid is the federal/state health care program for the poor. 42 U.S.C. § 1396 et seq. and 42 C.F.R. § 430.10 et seq. At the federal level, the Medicaid program is administered by the federal Department of Health and Human Services, through the Health Care Financing Administration. At the state level, each state's Medicaid program is required to be administered exclusively by a designated single state

agency, which, as indicated above, is DHS for the Medi-Cal program. 42 U.S.C. § 13196a(a)(5).

5. While it is not mandatory that a state participate in the Medicaid program, if a state chooses to do so, it must aboide by the governing provisions of the federal Medicaid laws and regulations. Those federal laws and regulations are implemented through the establishment of a "state plan" for medical assistance, which must be developed by the single state agency and contains various requirements under the governing federal statute and regulations. 42 U.S.C. § 1396a and 42 C.F.R. §430.10.

6. Under the controlling federal Medicaid regulations, specifically 42 C.F.R. Section 431.10(e), the single state agency must not delegate to other than its own officials authority to exercise administrative discretion in the administration or supervision of the state Medicaid plan or to issue policy, rules and regulations on program matters. By the same token, other state offices are not permitted to disregard, change, or disapprove of any policy, rule or regulation issued by the Medicaid agency or otherwise impair the functioning of the state Medicaid agency.

THE MEDI-CAL REQUIREMENTS

7. The Medi-Cal program expressly covers laboratory services furnished by independent clinical laboratories. Welf. & Inst. Code § 14133 and 22 C.C.R. §§ 51137.1, 51137.2, and 51211.2. Laboratory services are defined as the examination of materials derived from the human body for the purposes of diagnosing, preventing or treating any disease or impairment or the assessment of the health of a human being. 22 C.C.R. § 51137.2.

8. Providers of clinical laboratory services, such as ANL, perform testing on specimens from Medi-Cal patients and others only when such testing is ordered by an outside physician. The testing is ordered through a "requisition" sheet, which accompanies the laboratory specimen. Following the performance of the laboratory testing, a provider of clinical laboratory services must communicate the laboratory test results to the office of the ordering physician and must submit a bill

for payment for Medi-Cal laboratory testing to DHS within six month of the month of the testing. Welf. & Inst. Code § 14115.

9. DHS has contracted with a private company, EDS, to act as the Medi-Cal fiscal intermediary for pursposes of processing claims submitted by providers for Medi-Cal payment. See 22 C.C.R. § 51008. DHS' contract with the fiscal intermediary to process Medi-Cal payments is specifically permitted under the governing federal Medicaid regulations, and under state law and is part of the Medicaid State Plan. See 42 C.F.R. § 434.10 and Welf & Inst. Code § 14104.3.

10. EDS, the Medi-Cal fiscal intermediary, reviews each Medi-Cal claim submitted by a provider and determines the amount of Medi-Cal payment owing for services, including clinical laboratory services, furnished to Medi-Cal patients by applying Medi-Cal regulations, such as 22 C.C.R. Section 51529, which sets forth the Medi-Cal payment rates for clinical laboratory services.

11. After reviewing and processing a Medi-Cal claim submitted by a provider, the Medi-Cal fiscal intermediary determines whether or not to pay the provider and how much the provider should be paid. The fiscal intermediary advises the Controller of the sum owing the provider and the Controller is then required to promptly issue a check to the provider for that sum.

THE AUTHORIZED MEDI-CAL AUDIT PROCESS

12. Under federal Medicaid law, the single state agency must assure that there is an appropriate audit of providers' records. 42 C.F.R. § 447.202. To implement this federal requirement, the State Legislature authorized DHS, and only DHS, to audit amounts paid for services to providers for furnishing services to Medi-Cal beneficiaries in the manner and form prescribed by DHS. Welf. & Inst. Code § 14170(a)(1). DHS, in turn, has implemented a comprehensive Medi-Cal audit program, which includes the establishment of audit policies and procedures for routinely auditing Medical payments made to clinical laboratories on a postservice, postpayment basis. Indeed, DHS has established two separate divisions within DHS to audit and review Medi-Cal payments made to providers, including clinical laboratories.

13. Recognizing the complexity of the Medi-Cal rules regarding payment for Medi-Cal services, DHS, at the express direction of the Legislature (Welf. & Inst. Code §14171), has established an administrative appeal process to review grievances or complaints of providers arising from the findings of a Medi-Cal audit or examination. 22 C.C.R. §§ 51016-51047.

THE FACTS

14. Relying on purported authority in state law and an Interagency Agreement with DHS, the State Controller initially conducted a review of ANL's Medi-Cal claims for laboratory testing covering the period of January 9, 1997 to October 9, 1997. The purpose of this audit was to determine the provider's compliance with applicable provisions of the Medi-Cal program governing the performance of Laboratory services. This report concluded that ANL had been overpaid the sum of approximately $1.3 million by the Medi-Cal program for services previously rendered. This overpayment calculation was determined by the Controller using statistical extrapolation methodology. The Controller issued formal audit findings in a final report dated March 10, 1998. ANL timely appealed the Controller's findings to DHS.

15. The Controller conducted a follow-up audit of ANL's Medi-Cal claims covering the period of October 10, 1997 through March 6, 1998. This follow-up audit resulted in the issuance of a report indicating that ANL had been overpaid approximately $165,000 for services previously rendered. The State Controller issued audit findings from this second review in a final report dated May 4, 1998. ANL filed a timely appeal of the findings of the second report on May 6, 1998.

16. The two appeals were subsequently consolidated for hearing and decision by DHS. On June 15 and 16, 1998, consolidated appeals were heard by Robert L. Carisoza, an administrative law judge employed by DHS.

17. Among the issues raised by ANL in its administrative appeals was whether the State Controller had authority under the controlling federal Medicaid law to audit Medi-Cal payments. On February 1, 1999, the California Court of Appeal issued a published decision concluding

that the State Controller lacked authority under the governing federal Medicaid law to audit Medi-Cal payments to a provider because the State Controller was not part of the single state Medicaid agency responsible for administering or supervising the administration of the Medi-Cal program.

18. On April 15, 1999, the administrative law judge issued a proposed decision granting ANL's appeal in part and denying it in part. In his proposed decision, the administrative law judge concluded that the State Controller had the authority to audit Medi-Cal claims of a provider under federal and state law. The administrative law judge asserted that the Court of Appeal decision in Doctor's Medical Laboratory, Inc. v. Connell, was not "persuasive authority to the contrary" at the time he issued his proposed decision because the Court of Appeal's decision had not yet become "final."

19. On June 10, 1999, the Chief Deputy Director for DHS informed the State Controller and ANL that he was rejecting the proposed decision of the administrative law judge in this case and would be issuing a final decision of his own based upon the record.

20. On August 6, 1999, the Chief Deputy Director issued a final decision granting ANL's appeal in part and denying it in part. With respect to the authority of the State Controller, the Chief Deputy Director concluded that the State Controller did, in fact, have the authority to audit Medi-Cal claims notwithstanding the decision of the Court of Appeal, which had by then become final, in Doctor's Medical Laboratory, Inc. v. Connell. Even though the State Court of Appeal expressly concluded that the Controller "could not lawfully exercise power to audit provider payments and withhold alleged excesses," (69 Cal.App.4th at 897), the Chief Deputy Director concluded that because the Court of Appeal decision was purportedly not based on "a fully developed record," the Court of Appeal did not decide the audit authority of the Controller "standing alone." Thus, the Chief Deputy Director concluded that the Court of Appeal discussion of the Controller's audit authority was based on an incomplete record and is therefore not a "dispositive pronouncement" concerning the Controller's authority to audit Medi-Cal payments.

THE FINAL DECISION OF THE DIRECTOR OF DHS IS INVALID AND MUST BE SET AISDE

21. The decision of the Director of DHS (actually, the Chief Deputy Director of DHS) concerning the authority of the State Controller to conduct Medi-Cal audits is invalid under California Code of Civil procedure Section 1094.5 because, inter alia, it is inconsistent with the governing federal Medicaid law, as interpreted by the California Court of Appeal and other courts. Specifically, the Director of DHS was bound to abide by the final decision of the California Court of Appeal in connection with her quasi-judicial decision-making, just as a lower court is bound by the precedent established by the state Court of Appeal, even if the Director or a lower court disagrees with the reasoning of the Court of Appeal. The Chief Deputy Director misrepresented the state of the record in issuing the final decision when he alleged that ANL had waived further briefing and held that the United States District Court concluded that the State Controller could perform Medi-Cal audits. moreover, it is not true that the Court of Appeal did not have a "complete" record before it in the Doctor's Medical Laboratory case. To the contrary, the Department of Health Services and the Controller brought to the attention of the Court of Appeal and the Supreme Court in the Petition for Rehearing, Petition for Review, and Request for Depublication of the opinion, the very same information which the Chief Deputy Director concluded was not before the Court of Appeal.

22. In addition to being invalid because the Controller lacks the authority under federal Medicaid law to audit Medi-Cal payments, the final decision of the Director of DHS is arbitrary and capricious to the extent it imposes liability for a Medi-Cal overpayment on an independent clinical laboratory when the laboratory performs testing pursuant to an order of a physician, which misidentifies the patient for whom the testing was performed. Independent clinical laboratories perform laboratory testing only when ordered to do so by a physician. The physician orders laboratory testing through the submission of "requisitions" along with the specimen to be tested. Independent clinical laboratories must rely on the information in the laboratory requisition sheet to perform laboratory testing. The clinical laboratories are not

required to, and should not be required to, verify independently the identity of the patient from whom the referring physician obtained the specimen to be tested.

23. ANL has no further administrative remedies to exhaust to challenge the decision of the Director of DHS.

WHEREFORE, ANL prays that:

1. Upon motion, a peremptory writ of mandate be issued requiring the Director to set aside her final decision and to hold that the overpayment in question must be eliminated because it results from an unlawful audit by the State controller's Office, and, if necessary, to hold that ANL should not be penalized by imposing overpayment liability for laboratory testing performed by ANL pursuant to requisitions from ordering physicians which misidentify the patient from whom the laboratory specimen was obtained.

2. The Court award petitioner's costs of suit, including reasonable attorneys fees; and

3. The Court award petitioner such other and further relief as is deemed proper.

Dated: October 12, 1999

Respectfully submitted,

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PATRIC HOOPER

By:/s/ Patric Hooper
Patric Hooper

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SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

RCJ MEDICAL SERVICES, INC., DBA AMERICAN NETWORK LABORATORY, Petitioner,	) Case No. BS060056
v.	) NOTICE OF MOTION
THE DIRECTOR OF THE CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES, Respondent.	) AND MOTION FOR PEREMPTORY WRIT OF MANDATE
	) Date: February 18, 2000
	) Time: 9:30 a.m.
	) Dept.: 86

TO RESPONDENT, DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES, AND TO HER ATTORNEY OF RECORD, WILLIAM LOCKYER, ATTORNEY GENERAL:

PLEASE TAKE NOTICE that on February 18, 2000, at 9:30 am., in Department 86 of the within Court, at 111 North Hill Street, Los Angeles, California 90012, petitioner, RCJ Medical Services, Inc., will move the Court for an order granting a peremptory writ of mandate requiring the Director to set aside her final decision in this matter and to hold that the overpayment in question must be eliminated because it

results from an unlawful audit by the State Controller's Office, and further requiring the Director to pay petitioner's costs of suit, including reasonable attorneys fees.

Date; January 12, 2000

Respectfully submitted,

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FOR THE COUNTY OF LOS ANGELES

RCJ MEDICAL SERVICES, INC., DBA AMERICAN NETWORK LABORATORY, Petitioner, v. THE DIRECTOR OF THE CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES, Respondent.	) Case No. BS060056)) MEMORANDUM) OF POINTS AND) AUTHORITIES IN) SUPPORT OF) MOTION FOR) PEREMPTORY WRIT) OF MANDATE)) Date: February 18, 2000) Time: 9:30 a.m.) Dept.: 86

A. INTRODUCTION

By this action, RCJ Medical Services, Inc. ("ANL") seeks to set aside a final decision of the Director of the State Department of Health Services ("DHS") refusing to abide by the Final Decision of the Court of Appeal in the case of Doctor's Medical Laboratory, Inc. v. Connell (1999), 69 Cal.App.4th 891. As this Court knows, in Doctor's, the Court

of Appeal concluded that the State Controller was prohibited by federal Medicaid law from auditing Medi-Cal payments to providers of Medi-Cal services, including independent laboratories.

Notwithstanding this binding precedent, and subsequent events which confirm the precedential nature of the Doctor's decision, the Director of DHS has nevertheless held in this case that the Controller does, in fact, have the authority to audit Medi-Cal Providers, and specifically ANL.

For the reasons set forth below, among others, the Court is respectfully requested to set aside the Director's Final Decision in this case and to order that the overpayment in question be eliminated because it results from an unlawful audit by the State Controller's Office. Additionally, because of the arbitrary nature of the Director's Final Decision and because the Final Decision is violation of the governing federal Medicaid law, ANL respectfully requests the Court to order the Director of DHS to pay its reasonable attorneys fees.

B. NO ADMINISTRATIVE RECORD IS REQUIRED TO RESOLVE THIS JURISDICTIONAL DISPUTE

While this case involves judicial review of a final decision of the Director of DHS following the holding of an administrative hearing, which ordinarily requires the Petitioner to obtain and present to the Court a record of the administrative proceedings, a record is not required in this case because of the purely legal nature of the issue to be resolved. See California Administrative Mandamus, § 8.4 (CEB 2d. Ed. 1989) and see also Elizabeth D. v. Zolin (1993) 21 Cal.App.4th 347, 355.

In this case, Petitioner is not challenging the evidentiary sufficiency of the findings made by the Director of DHS. Rather, Petitioner, ANL, is challenging the authority of the State Controller to conduct Medi-Cal audits, and specifically the Medi-Cal audit at issue. The Director of DHS contends that federal law does not prohibit the State Controller from conducting such audits, and ANL contends that federal law does prohibit the State Controller from conducting Medi-Cal audits, especially the audit at issue. There is no need nor requirement for the preparation of an administrative record to resolve this issue, which has

already been resolved fully by the courts.

In any event, all the facts necessary to resolve the legal issue in dispute are set forth clearly in the Final Decision of the Director of DHS in this case, a copy of which is attached as Exhibit A.

C. THE RELEVANT, MATERIAL, UNDISPUTED FACTS

As indicated in the Director's Final Decision, the State Controller conducted audits of ANL's Medi-claims for laboratory services submitted during the period of January 9, 1997 through March 6, 1998. The purpose of the review was to determine whether ANL's claims complied with the applicable provisions of the Medi-Cal program. See Director's Final Decision, para. II, pp. 5-6.

On March 10 and May 4, 1998, the Controller issued her audit findings, concluding that ANL had been overpaid the sum of $1,461,567 by the Medi-Cal program for the services rendered. ANL filed timely administrative appeals of the findings on March 19 and May 6, 1998. Director's Final Decision, para. II, p.6.

In June 1998, a hearing was held before a DHS administrative law judge. On April 1, 1999, the administrative law judge filed a proposed decision (copy attached as Exhibit B), which upheld the authority of the Controller to conduct Medi-Cal audits because the decision in Doctor's Medical Laboratory, Inc., had not yet become final, but granted ANL's administrative appeal regarding some issues. The audit findings of the Controller regarding certain other issues were upheld by the administrative law judge.

On May 28, 1999, ANL informed the Office of Administrative Hearing and Appeals that the decision in Doctor's Medical Laboratory had become final and requested that the appeal be granted in its entirety based upon that decision. Director's Final Decision, p.3. The Director of DHS issued a Final Decision on August 6, 1999, concluding that notwithstanding the Court of Appeal decision, the Controller had the authority to audit the Medi-Cal claims at issue and that the federal Medicaid law did not prohibit her from exercising such authority in this case. According to the Director of DHS:

1. A federal district court in another case had impliedly accepted that the Controller can audit Medi-Cal providers (Director's Dec. at pp. 7-8);
2. The Doctor's Medical Laboratory decision of the Court of Appeal did not really decide whether the Controller had the authority to audit Medi-Cal claims (Director's Final Dec. at pp. 8-9); and
3. "With all due respect for the opinion of the Court of Appeal" in Doctor's Medical Laboratory, the Court's very brief discussion of the audit subject, was based on an incomplete record, and did not "appear to be a dispositive pronouncement concerning the Controller's authority to audit." (Director's Final Dec. at pp. 9-10).

D. SUBSEQUENT EVENTS

Subsequent to the issuance of the August 1999 Final Decision in this case, the United States District Court for the Central District of California, Senior Judge Robert J. Kelleher, the very same Judge who issued the decision relied on by the Director of DHS in her final decision in this case (as described above), issued a definitive Memorandum Opinion and Order concluding unequivocally that the federal Medicaid law and regulations prohibit the State Controller from auditing Medi-Cal claims and payments. See the Nov. 12, 1999, Decision and Order of the District Court in San Lazaro Association, Inc., dba Biomedical Laboratory v. Kathleen Connell, Controller of the State of California, a copy attached as Exhibit C.

In the November 12, 1999 Decision, the District Court rejects the very same arguments asserted by the Director of DHS in issuing her August 1999 Final Decision in this case. For example, the District Court concludes that the Controller violated federal Medicaid laws by exercising discretion during Medi-Cal audits and reviews, which exercise of discretion is prohibited by the federal Medicaid laws and regulations. See Exhibit C, Slip Op. at 9-12. Relying expressly on the California Court of Appeal's Decision in the Doctor's Medical Laboratory case, the District Court also concluded that the Controller's

exercise of discretionary authority is not saved by the subsequent review of DHS. See Exhibit C, Slip Op. pp. 13-14. Finally, the District Court concluded that the decision of the California Court of Appeal in the Doctor's Medical Laboratory case explicitly prohibits the Controller from conducting audits of Medi-Cal payments and claims. The Court rejected the argument that the California Court of Appeal did not fully appreciate the audit issue and did not have a complete record before it. See Exhibit C, Slip Op. at 14-18.[1/]

More recently, the Director's own administrative law judges, including Judge Carisoza, the Administrative Law Judge in this case, have also reached the conclusion that the decision of the Court of Appeal in Doctor's Medical Laboratory, Inc. compels the conclusion that the Controller is prohibited by the federal Medicaid law from auditing Medi-Cal payments and claims. See, for example, the proposed decision of Administrative Law Judge Carisoza in Angela's Discount Pharmacy, Medi-Cal Audit Appeal No. SR9-0998-355-RC, a copy attached as Exhibit D.

E. ARGUMENT

As pointed out by the District Court Judge in the San Lazaro Association, Inc. case and DHS Administrative Law Judge Carisoza in the Angela's Discount Pharmacy appeal, the California Court of Appeal in the Doctor's Medical Laboratory case clearly and unequivocally

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1. The Controller has appealed the District Court's Nov. 12, 1999 Decision and has filed various motions in the District Court to have the Decision set aside. However, as of the date of this Memorandum, the Nov. 12, 1999 Memorandum Decision and Order remains in full force and effect. Indeed, under the governing law, the Controller and the Director of DHS are collaterally estopped from rearguing the question of the Controller's authority to conduct Medi-Cal audits so long as the November 12, 1999 ruling remains in effect. See Lumpkin v. Jordan (1996), 49 Cal.App.4th 1223, 1230.

concluded that the federal Medicaid law not only prohibits the Controller from withholding alleged overpayments from Medi-Cal providers but also prohibits the Controller from conducting Medi-Cal audits. The California Court of Appeal in Doctor's Medical Laboratory expressly concluded that "the Controller could not lawfully exercise power to audit provider payments and withhold alleged excesses." Doctor's Medical Laboratory, Inc. v. Connell, 69 Cal.App.4th at 897. As indicated above, the Court of Appeal also concluded that the subsequent review of the Controller's findings by DHS would not save the improper delegation of authority from State DHS to the Controller. Id. The final decision of the Court of Appeal is binding on this Court notwithstanding the Director of DHS' disagreement with the reasoning of the California Court of Appeal.

The Director of DHS will no doubt attempt to rely on post hoc rationalizations to attempt to convince this Court that the Court of Appeal, the United States District Court, and her own administrative law judges are wrong regarding the lack of authority of the Controller to audit Medi-Cal payments and claims. For example, the Director of DHS will no doubt point out that she recently amended the California State Medicaid Plan to acknowledge that the State Controller performs Medi-Cal audits. She will add that the federal agency responsible for administering the Medicaid Program, the Health Care Financing Administration, approved the State Plan Amendment on December 17, 1999, the same day it was submitted to that agency. She will then argue that such approval constitutes persuasive authority regarding the interpretation of the governing federal Medicaid laws and regulations. (She has made these identical arguments in several other cases.) However, the arguments must be rejected for a variety of reasons.

First and foremost, as indicated above, this Court is bound to follow the final decision of the California Court of Appeal regardless of whether that decision differs from a subsequent interpretation of the governing federal Medicaid laws and regulations by a federal agency. Second, the fact that a federal agency approved the State Plan provision is of no impact since the State Plan provision is inconsistent with the plain language of the governing regulation. Compare Children's Hospital and Health Center v. Belshe, 188 F.3d 1090, 1098 (9th Cir. 1999) (copy

attached as Exhibit E) [HCFA approval of disputed Medicaid State Plan provision is of no impact since the State Plan provision is inconsistent with the plain language of the law]. Third, and finally, regardless of the prospective impact of the State Plan Amendment, the effective date of the amendment was July 1, 1998, which postdates the February 1998 audit findings at issue. Medicaid Plan Amendments are not valid unless and until they are approved by the federal government, which approval did not occur here until December 17, 1999. See Exeter Memorial Hospital Association v. Belshe, 145 F.3d 1106 (9th Cir. 1998), copy attached as Exhibit F.

Thus, even subsequent events do not allow the Director's decision in this case to be upheld. Clearly and simply, under the governing precedent established by the California Court of Appeal in the Doctor's Medical Laboratory case, the State Controller is prohibited from auditing Medi-Cal payments and claims and thus the Controller's audit findings in this case may not be upheld but must be declared to be null and void.

F. ANL SHOULD BE AWARDED ATTORNEYS FEES

One cannot imagine more arbitrary and capricious action than that engaged in by the Director of DHS in this case. Because she disagrees with the reasoning of the California Court of Appeal in the Doctor's Medical Laboratory, Inc. case, she refuses to abide by it. Thus, even though this Court must abide by the precedent of the Court of Appeal, the Director apparently believes that when she exercises her quasi-judicial responsibility, she can ignore those decisions of the Court of Appeal which she believes to be erroneously reasoned. This position makes a mockery of the Medi-Cal administrative appeal process and purports to place the Director of DHS above the law.

Government Code Section 800 is intended to provide relief to a private party which finds itself in the position that ANL finds itself. ANL has been forced to seek relief from the court to remedy the violation of the federal Medicaid law which was established in the Doctor's Medical Laboratory case. Due solely to the arbitrary action of the Director of DHS, ANL has been required to incur substantial legal fees and expenses to vindicate its rights which it would not have been

required to incur if the Director had simply followed the law, as she is required to do.

In addition to being entitled to an award of attorneys fees under Government Code Section 800, ANL is also entitled to an award of attorneys fees under the Civil Rights Act, 42 U.S.C. § 1988, since the Director's final decision is inconsistent with the governing federal Medicaid law. The courts routinely award attorneys fees to prevailing parties under 42 U.S.C. Section 1988 in actions in which the prevailing party is able to establish that state officials violated the governing provisions of the controlling federal Medicaid laws and regulations. See Green v. Obledo (1984) 161 Cal.App.3d 678.

As in Green v. Obledo, in this case, the Court must determine whether ANL is entitled to attorneys fees under Section 1983 by the pleadings and by the governing federal Medicaid law. The inquiry must focus on whether the two essential elements of a Section 1983 action are present (1) whether the conduct complained of was committed by a person acting under color of state law, and (2) whether the conduct deprived a person of rights, privileges, or immunity secured by the Constitution or laws of the United States. 161 Cal.App.3d at 682. Here, the Director of DHS is acting under color of state law (she reviewed the proposed decision pursuant to Welfare and Institutions Code Section 14171) and her Final Decision deprives ANL of the rights to which it is entitled under the laws of the United States, i.e., the right not to be audited by the California State Controller.

In Green, as here, relief is sought through the grant of a Writ of Mandate. However, because the underlying allegations demonstrate a deprivation of the rights owing ANL under the federal law, the court may allow attorneys fees under 42 U.S.C. § 1988. 161 Cal.App.3d 682. See also Filipino Accountants Association v. State Board of Accountancy (1984) 155 Cal.App.3d 1023.

Thus, in addition to requiring the Director of DHS to set aside the audit findings at issue, the Court is respectfully requested to order the Director to pay ANL's reasonable attorneys fees.

Dated: January 12, 2000

Respectfully submitted,

HOOPER, LUNDY & BOOKMAN, INC

By:/s/ Patric Hooper
PATRIC HOOPER
Attorneys for Petitioner, RCJ
Medical Services, Inc.

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT

RCJ MEDICAL SERVICES, Inc., (dba) AMERICAN NETWORK LABORATORY Plaintiff(s), and RESPONDENTS, vs. The DIRECTOR of the STATE DEPARTMENT of HEALTH SERVICES, Defendant(s), and APPELLANTS,	Case No.BS060056 Notice(s) of Appeal Filed: JULY 19, 2000 VOLUME 2 OF 2 VOLUMES

CLERK'S TRANSCRIPT

HONORABLE DAVID P. YAFFE, JUDGE.

Appeal from the Superior Court, Los Angeles County

APPEARANCES:

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PATRICIA L. NAGLER, Deputy ATTY. GENERAL
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Counsel for APPELLANT, Dir. of the State Dept. of Health

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1875 CENTURY PARK EAST, SUITE 1600
LOS ANGELES, CA 90067-2799
Tel.# (310) 551-8165
Counsel for RESPONDENT, RCJ Medical Ser., Inc., et al.

DECLARATION OF JAMES R. DANDRIDGE

I, James R. Dandridge, declare that I have personal knowledge of the matters stated herein, and if called upon to testify, I could and would testify competently thereto.

1. I am the Chief of the Medical Review Branch (Medical Review) in Audits and Investigations, Department of Health Services (DHS). I have held this position for 13 years. Medical Review is responsible, among other tasks, for oversight of fraudulent and abusive billing by Medi-Cal fee-for-service non-institutional providers, such as physicians, laboratories, durable medical equipment suppliers, and suppliers of medical transportation.

. . .

17. Providers submit claims for payment for Medi-Cal services to Electronic Data Systems ("EDS"), the fiscal intermediary, i.e., claims processor, for DHS. EDS utilizes a mechanized claims processing system with a limited edit capability for screening improper claims. The fact that EDS has cleared a claim for payment does not mean that the claim has a final approval by DHS. EDS forwards those claims that it identifies as eligible for payment to the State Controller's Office ("SCO"), which issues a warrant and mails it to the provider. Whenever DHS institutes a withhold of Medi-Cal payments pursuant to 42 Code of Federal Regulations, section 4545.23, DHS implements the withhold by notifying EDS to first process the claims within EDS and then, instead of forwarding them to SCO for payment, to place the withheld funds into a trust account. DHS implements the withhold on payments for those claims that have already been processed by EDS and forwarded to SCO by notifying SCO to hold all warrants for withheld funds that it has not yet mailed to the provider. These procedures for implementing a withhold of Medi-Cal payments instituted by DHS pursuant to 42 Code of Federal Regulations, section 455.23 are the same whether or not the evidence of fraud or willful misrepresentation relied on by DHS as a basis for the withhold is discovered in a review by DHS or SCO.

I declare under penalty of perjury that the above is true and correct.

Executed this 28th day of January, 2000, at Sacramento, California.

/s/ James R. Dandridge
James R. Dandridge, Chief
Medical Review Branch

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF LOS ANGELES

DATE: 05/02/00	DEPT. 86
HONORABLE DAVID YAFFE JUDGE	C. HUDSON DEPUTY CLERK
	A. GODINEZ, CRT ASST
HONORABLE JUDGE PRO TEM	NONE ELECTRONIC RECORDING MONITOR
NONE DEPUTY SHERIFF	DOLHMAN AUDIO VISUAL REPORTER

9:30 a.m. BS060056

RCJ MEDICAL SERVICES, INC.
vs.
DIRECTOR OF THE STATE DEPARTMENT

Plaintiff
Counsel PATRIC HOOPER, (X)

Defendant
Counsel PATRICIA L. NAGLER (X)

NATURE OF PROCEEDINGS:

HEARING ON PETITION FOR WRIT OF MANDATE;

Matter comes on for trial.

The administrative record lodged in this case is admitted in evidence by reference to the court's file.

Petition for Writ of Mandate is granted.

The issues in this case are conclusively determined by the Court of Appeal decision in DOCTOR'S MEDICAL LABORATORY INC. v. CONNELL, 69 Cal.App.4th 891 (1999), which decision is final and binding upon this court. In its decision the Court of Appeal held that the Controller could not lawfully exercise power to audit payments of Medi-

Cal claims submitted by providers like petitioner.

To the extent that respondent's final administrative decision holds that the State Controller has the authority to audit Medi-Cal claims, and insofar as it relies upon said audit for any finding of fact, said decision is inconsistent with the aforesaid decision of the Court of Appeal, respondent has not proceeded in the manner required by law, and its final administrative decision constitutes an abuse of discretion within the meaning of Section 1094.5(b) of the Code of Civil Procedure.

MINUTES ENTERED
05/02/00
COUNTY CLERK

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF LOS ANGELES

DATE: 05/02/00	DEPT. 86
HONORABLE DAVID YAFFE JUDGE	C. HUDSON DEPUTY CLERK
	A. GODINEZ, CRT ASST
HONORABLE JUDGE PRO TEM	NONE ELECTRONIC RECORDING MONITOR
NONE DEPUTY SHERIFF	DOLHMAN AUDIO VISUAL REPORTER

9:30 a.m. BS060056

RCJ MEDICAL SERVICES, INC.
vs.
DIRECTOR OF THE STATE DEPARTMENT

Plaintiff
Counsel PATRIC HOOPER, (X)

Defendant
Counsel PATRICIA L. NAGLER (X)

NATURE OF PROCEEDINGS:

Counsel for petitioner is to submit a proposed judgment and a proposed writ to this department within 10 days, with a proof of service showing that copies of said documents have been served upon opposing counsel. The court will hold said documents for 10 days before signing and filing the judgment and causing the clerk to issue the writ.

The administrative record is ordered forthwith returned to the offering party.

MINUTES ENTERED
05/02/00
COUNTY CLERK

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Attorneys for Petitioner

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

RCJ MEDICAL SERVICES, INC., DBA AMERICAN NETWORK LABORATORY, Petitioner, v. THE DIRECTOR OF THE CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES, Respondent.	) Case No. BS060056)) JUDGMENT) GRANTING) PEREMPTORY) WRIT OF) MANDATE)))

Petitioner's Motion for a Peremptory Writ of Mandate in this matter came on regularly for hearing before the Honorable David P. Yaffe, Judge presiding in Department 86 of the within Court, on May 2, 2000. Petitioner, RCJ Medical Services, Inc., was represented by Patric Hooper of Hooper, Lundy & Bookman, Inc., and respondent Director of the State Department of Health Services, was represented by Patricia L. Nagler, Deputy Attorney General.

The Court having considered all of the pleadings and the written and oral argument of counsel, and having issued the tentative decision which is reflected in its Minute Order of May 2, 2000, and which constitutes its Statement of Decision,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that a peremptory writ of mandate be issued requiring the respondent, the Director of the State Department of Health Services to set aside her Final Decision in this case insofar as it relies upon the audit findings of the State Controller.

IT IS FURTHER ORDERED that plaintiff shall recover its costs of suit in the amount of $3,375.00.

DATED: May 18, 2000

/s/ David P. Yaffe
DAVID P. YAFFE

Judge of the Superior Court

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Attorneys for Petitioner

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

RCJ MEDICAL SERVICES, INC., DBA AMERICAN NETWORK LABORATORY, Petitioner,	) Case No. BS060056)) PEREMPTORY) WRIT OF
v.	) MANDATE
THE DIRECTOR OF THE CALIFORNIA STATE , ETC. Respondent.	))))

TO RESPONDENT DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES, STATE OF CALIFORNIA:

Judgment having been entered in this proceeding ordering that a peremptory writ of mandate issue from this Court, YOU ARE HEREBY COMMANDED upon receipt of this Writ to:

1. Set aside the Final Decision of the State Department of Health Services in this matter insofar as it relies upon the audit findings of the State Controller; and

2. Pay petitioner its costs of suit in the amount of $_____.

DATED: May 19, 2000

/s/ JOHN A. CLARKE, CLERK
CLERK OF THE SUPERIOR COURT

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
DIVISION FIVE

RCJ MEDICAL SERVICES, INC. Plaintiff, Respondent, v. THE DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES, Defendant, Appellant,	Case No. B143160

LOS ANGELES COUNTY SUPERIOR COURT CASE NO. BS060054
THE HONORABLE DAVID P. YAFFE

APPELLANT'S MOTION FOR JUDICIAL NOTICE; MEMORANDUM OF POINTS AND AUTHORITIES; ORDER - VOLUME I AND II (PAGES 1-433)

BILL LOCKYER, Attorney General
of the State of California
CHARLTON G. HOLLAND, III, Senior
Assistant Attorney General
JOHN H. SANDERS, Lead Supervising
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Attorneys for Appellant, The Director
of the State Department of Health Services

APPELLANT'S MOTION FOR JUDICIAL NOTICE

Pursuant to California Rules of Court, Rules 14.5 and 41 and Evidence Code §459, appellant Director of the State Department of Health Services respectfully requests that the Court take judicial notice of the following:

1. The record on appeal and the Court of Appeal file in Doctor's Medical Laboratory, Inc. v. Kathleen Connell, as Controller of the State of California, 69 Cal.App.4th 891 (2 Civil No. B119355, Los Angeles County Superior Court Case No. BC181780) ("Doctor's "). The documents therein that are referred to in Appellant's Opening Brief are attached collectively hereto as Exhibit A.

2. Documents evidencing the fact that Doctor's Medical Laboratory, Inc. ("DML") has been reimbursed the amount (plus interest) that was withheld by the State Controller's Office ("SCO" or "State Controller") prior to DML's administrative hearing and which was the subject of Doctor's, and further evidencing the fact that the Director's Final Decision resulted in a determination that DML was overpaid $1,004,905 for claims submitted during the review period September 6, 1996 through November 20, 1997, which DML does not contest. These documents include the Declaration of Walter Barnes and a letter dated May 31, 2000 from Michelle Marks to DML's attorney Patric Hooper. Copies of these documents are attached collectively hereto as Exhibit B.

3. Documents providing the history of the single state agency provisions of federal Medicaid law, 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10. These documents, which are attached collectively hereto as Exhibit C, include:

a. Department of Health, Education and Welfare, official Handbook of Public Assistance ("Handbook") (1963-1964), Introduction and Part II, sections 1000, 2000, 2100, 2200, 2300, and 2310, and Supplement D-Medical Assistance Programs Under Title XIX of the Social Security Act (1966-1967), Record of Recipient of Handbook Supplement D Transmittals (5/16/67), Checklist for Supplement D - Medical Assistance Programs, and sections D-2000, D-2100, D2110, D-2120, D-2130, and D-2140. The Handbook is the official medium for

issuance of interpretations and instructions concerning requirements of the public assistance titles of the Social Security Act;

b. 42 Code of Federal Regulations ("C.F.R") §431.10;

c. The following excerpts from the Federal Register ("FR") 35 FR 8780-8781 (6/15/70), 36 FR 3860-3862 (2/27/71), 39 FR 34542-34543 (3/11/74), 39 FR 9512-9513 (9/26/74), 44 FR 17926-17930, 17940-17941 (3/23/79), and 45 FR 56682-56686 (8/25/80);

d. Statutes at Large of the United States of America, Title I - Grants to States for Old-Age Assistance, §2(a) - (1935);

e. 1965 United States Code Congressional and Administrative News, (U.S.C.C.A.N.) 1943, 1952, 2015-2016, 2145, 2245, 2291, 2295, copies of which are contained in Exhibit C; and

f. Robert B. Stevens, Statutory History of the United States Income Security (1970), pages 64-65, 78-82, 100, copies of which are contained in Exhibit C.

4. U.S. District Court and Ninth Circuit Court of Appeals documents in related cases, which include the following, copies of which are collectively attached hereto as Exhibit D:

a. Order Granting Preliminary Injunction in Health Line Clinical Laboratory, Inc. v. Connell (U.S. Dist.Ct. (C.D.Cal.)) No. CV-98-1620-RJK;

b. Temporary Restraining Order, Preliminary Injunction and Notices of Appeal in San Lazaro Association, Inc., dba Biomedical Laboratory, v. Kathleen Connell, Controller of the State of California, (U.S.D.C. Case No. CV-98-06216 RJK) (Ninth Circuit Case Nos. 00-55-65 and 00-55610) ("San Lazaro"), which contain the district court's decisions and orders appealed from;

c. Temporary Restraining Order, Preliminary Injunction and Notice of Appeal in Clinical Care Laboratory, Inc. v. Kathleen Connell, Controller of the State of California, et al., (U.S.D.C., Central District of California, Case No. CV-98-8425-RJK) (Ninth Circuit Case No. 00-55963) ("Clinical Care"), which contain the district court's decisions, orders, and judgments appealed from;

d. Notice of Appeal in Khachik Simonyan and Oganes Nagapetyan v. Kathleen Connell, etc., et al., (U.S.D.C. Case No. CV-99-02420 RJK) (Ninth Circuit Case No. 00-55377) ("Simonyan"), which

contains the district court's decisions, orders, and judgment appealed from;

e. Ninth Circuit Court of Appeal Order Consolidating Case Nos. 00-55377, 00-55065, 00-55610 and 00-55963;

f. December 7, 1998 transcript in Clinical Care; and

g. December 21, 1999 transcript in FTS Enterprises, Inc., doing business as California Clinical Laboratories vs. Kathleen Connell, Controller of the State of California, and Diana M. Bonta, R.N., Dr. P.H. Director of the California Department of Health Services, State of California, (U.S.D.C., Central District of California, 99-11471-RJK); and

5. Amicus Brief for the United States Department of Health and Human Services, in Support of Defendants-Appellants, and in Favor of Reversal of the Judgments Below (Ninth Circuit Case Nos. 00-55963, 00-55065, 00-55610 and 00- 55377), a copy of which is attached hereto as Exhibit E;

6. 22 California Code of Regulation §51016 et seq., a copy of which is attached hereto as Exhibit F; and

7. 42 C.F.R. §§431.10-430.20 and 455.23, a copy of which is attached hereto as Exhibit G; and

8. 1997 Interagency Agreement between the Department of Health Services and the State Controller's Office, attached as Exhibit H.

DATE: February 28, 2001

BILL LOCKYER, Attorney General
of the State of California
CHARLTON G. HOLLAND, III, Senior
Assistant Attorney General
JOHN H. SANDERS, Lead
Supervising Deputy Attorney General
PATRICIA L. NAGLER
Deputy Attorney General

BY: /s/ Patricia L. Nagler
PATRICIA L. NAGLER
Attorneys for Respondent

MEMORANDUM OF POINTS AND AUTHORITIES

Appellant Director of State Department of Health Services brings this motion for judicial notice pursuant to California Rules of Court, Rules 14.5 and 41 and Evidence Code §459.

Evidence Code §459(a) provides as follows:

> "The reviewing court shall take judicial notice of (1) each matter properly noticed by the trial court and (2) each matter that the trial court was required to notice under Section 451 or 453. The reviewing court may take judicial notice of any matter specified in Section 452. The reviewing court may take judicial notice of a matter in a tenor different from that noticed by the trial court."

The matters which appellant requests this Court to take judicial notice of are embraced within Evidence Code §452, subdivisions (a), (b), (c), (d), (e), and (h). With the exception of item 1, the Record on Appeal and the pleadings filed in Doctor's, a copy of each of the matters appellant requests the Court to take judicial notice of is attached hereto. As to item 1, copies of those documents referred to in Appellant's Opening Brief are attached hereto.

The central issue in this case is whether the single state agency provisions of federal Medicaid law, 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10, prohibit the State Controller ("Controller" or "SCO") from performing Medi-Cal audits on behalf of the California Department of Health Services ("DHS") and require that DHS set aside a final administrative decision in an audit appeal if it is based on findings from an SCO audit. In granting a petition for writ of mandate pursuant to C.C.P. §1094.5, the trial court stated that "[t]he issues in this case are conclusively determined by the Court of Appeal decision in Doctors Medical Laboratory Inc. v. Connell, 69 Cal.App.4th 891 (1999)." (CT 381-382; 393-394) The judgment ordered that a peremptory writ of mandate be issued requiring the Director to set aside her final decision in this case, which granted in part and denied in part RCJ's appeal from an audit determination, and to void the audit findings of the State

Controller, which gave rise to the Final Administrative Decision under review.

Appellant requests that the Court take judicial notice of the record on appeal and the pleadings in Doctor's in order to be able to fully appreciate why the issues herein were not conclusively determined in Doctor's. For example, the Court of Appeal decision in Doctor's modified the judgment of the trial court to require the Controller to pay to Doctors all amounts approved for payment by DHS' fiscal intermediary, i.e. "Claims process", EDS. "As so modified, the judgment [was] affirmed." (Doctor's, at p. 898) The subject amounts were withheld by the Controller prior to Doctor's administrative hearing. A review of the trial court's judgment and statement of decision in its minute order reveals that the trial court denied Doctor's request to enjoin the Controller from auditing, both sides appealed, and the judgment was affirmed except for the Controller's withhold. A review of the pleadings will show that the U.S. District Court's unpublished decision and order granting a preliminary injunction against the Controller's withhold of Medi-Cal payments in Health Line Clinical Laboratory, Inc. v. Connell, (U.S.D.C. No. CV-98-1620-RJK) ("Health Line"), cited in Doctor's at page 897, footnote 1 as reaching the same conclusion on the same reasoning as Doctor's, did not enjoin the Controller from auditing Medi-Cal claims and payments, did not enjoin DHS from delegating auditing authority to the Controller, and did not prohibit DHS from relying on findings from an SCO audit in issuing a Final Administrative Decision. To the contrary, in Health Line the district court expressed its expectation that administrative proceedings would go forward before DHS' Office of Administrative Hearings and Appeals and that the Controller would continue to perform Medi-Cal audits.

Significantly, in Doctor's the Court of Appeal stated, "Neither side has cited legislative history or case law discussing the legislative and regulatory reasons for the single agency and nondelegation rules." The matters in item 3 which appellant requests the Court to take judicial notice of provide the history of the single state agency provisions of federal Medicaid law, 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10. This history fully supports appellant's position that the single state agency provisions do not prohibit DHS from delegating Medi-Cal

auditing authority to the State Controller.

The matters in item 4 which appellant requests the Court to take judicial notice of are noticeable matters in federal district court cases which have been deemed "related" to the Health Line case cited in Doctor's I, some of which have been cited in the trial court. The central issue in these cases is the same as the central issue before this Court: whether the single state agency requirements of federal Medicaid law, 42 U.S.C. §1396a(a)(5) and 42 C.F.R. §431.10, prohibit DHS from delegating to the State Controller the authority to conduct Medi-Cal audits on its behalf. Three of these cases, San Lazaro Association, Inc., dba Biomedical Laboratory, v. Kathleen Connell, Controller of the State of California Case Nos. 00-55-65 and 00-55610 (U.S.D.C. Case No. CV-98-06216 RJK), Clinical Care Laboratory, Inc. v. Kathleen Connell, Controller of the State of California, et al. Case No. 00-55963 (U.S.D.C., Central District of California, Case No. CV-98-8425-RJK), and Khachik Simonyan and Oganes Nagapetyan v. Kathleen Connell, etc., et al. Case No. 00-55377 (U.S.D.C. Case No. CV-99-02420 RJK) are now pending before the United States Court of Appeals for the Ninth Circuit and have been consolidated on appeal.

The Amicus Brief for the United States Department of Health and Human Services, in Support of Defendants-Appellants, and in Favor of Reversal of the Judgments Below, item 5 which appellant requests the Court to take judicial notice of, has been filed on behalf of DHS and the State Controller in the consolidated cases pending before the Ninth Circuit. The Amicus Brief asserts that (1) Medicaid providers are not the intended beneficiaries of the single state agency requirement and, therefore, have no right enforceable through 42 U.S.C. §1983 to compel a state's compliance with that requirement; and (2) Medicaid regulations, and specifically 42 C.F.R. §431.10, permit the designated State Medicaid agency to select another state agency to conduct audits of Medicaid providers.

The Health Care Financing Administration ("HCFA") is the agency within the federal Department of Health and Human Services designated by Congress to administer the Medicaid program at the federal level. (AMISUB (PSL) v. State of Colo. DSS (10th Cir. 1989) 879 F.2d 789, 794) The United States Supreme Court has "long recognized that

considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer." (Chevron, U.S.A., Inc. v. Natural Resources Defenses (1984) 467 U.S. 837, 842-845.) "When the construction of an administrative regulation rather than a statute is in issue, deference is even more clearly in order." (Udall v. Tallman, (1965) 380 U.S. 1, 16-17.) HCFA's interpretation of its own implementing regulation, 42 C.F.R. § 431.10(e), as allowing the State Controller to audit Medi-Cal claims on behalf of DHS is consistent with 42 U.S.C. § 1396a(a)(5) and 42 C.F.R. § 431.10(e) and is entitled to great deference. (See Chevron, U.S.A., Inc. v. Natural Resources Defense Council, (1984) 467 U.S. 837, 842-845; Udall v. Tallman, (1965) 380 U.S. 1, 16-17; Montana Power Co. v. Environmental Protection Agency, (9th Cir. 1979) 608 F.2d 334, 344-345.)

The matters contained in item 6 are DHS regulations regarding Medi-Cal provider audit appeals.

The matters contained in item 7 are federal regulations regarding State Plans and withholds of Medi-Cal payments to providers by the single state agency based on evidence of fraud or willful misrepresentation. In addition, the document contained in item 8 is the 1997 Interagency Agreement between the Department of Health Services and the State Controller's Office, which was the discussed in Doctor's.

The issue before the Court is one of great importance to California, as well as to other states. In order that the Court have a full and complete record upon which to base its decision and to promote the interests of justice, appellant Director of the California Department of Health Services respectfully asks the Court to take judicial notice of the requested matters.

DATED: February 28, 2001

BILL LOCKYER, Attorney General
CHARLTON G. HOLLAND, III
Senior Assistant Attorney General
JOHN H. SANDERS
Lead Supervising Deputy Attorney General
PATRICIA L. NAGLER
Deputy Attorney General

BY: /s/ Patricia L. Nagler
PATRICIA L. NAGLER
Attorneys for Appellant, The Director
of the State Department of Health Services

ORDER

FOR GOOD CAUSE SHOWN, appellant Director of the California Department of Health Services' Motion for Judicial Notice is hereby granted and this Court shall take judicial notice of the matters requested therein.

IT IS SO ORDERED.

/s/ David P. Yaffe
PRESIDING JUSTICE

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
DIVISION FIVE

RCJ MEDICAL SERVICES, INC. Plaintiff, Respondent, v. THE DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES, Defendant, Appellant,	Case No. B143160

LOS ANGELES COUNTY SUPERIOR COURT CASE NO. BS060054
THE HONORABLE DAVID P. YAFFE

APPELLANT'S MOTION FOR JUDICIAL NOTICE; MEMORANDUM OF POINTS AND AUTHORITIES; ORDER - VOLUME I OF II (PAGES 1-139)

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EXHIBIT A

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT

DOCTOR'S MEDICAL SERVICES, INC. Plaintiff(s), and APPELLANTS vs. KATHLEEN CONNELL, CONTROLLER OF THE STATE OF CALIFORNIA Defendant(s) and RESPONDENTS	Case No. BC181780 Notice(s) of Appeal Filed: FEBRUARY 3, 1998 FEBRUARY 23, 1998 VOLUME 1 OF 1 VOLUMES

CLERK'S TRANSCRIPT

HONORABLE DAVID YAFFEE, JUDGE

Appeal from the Superior Court, Los Angeles County

APPEARANCES:

HOOPER, LUNDY & BOOKMAN, INC.
PATRIC HOOPER
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LOS ANGELES, CA 90067-2799
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Counsel for APPELLANT, DOCTOR'S MEDICAL LABORATORY, INC.

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DEPUTY ATTORNEY GENERAL
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LOS ANGELES, CA 90013
Tel.# (213) 8987-2113
Counsel for RESPONDENT, KATHLEEN CONNELL, CONTROLLER OF THE STATE OF CALIFORNIA

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF LOS ANGELES

DATE: 01/12/98	DEPT. 86
HONORABLE DAVID YAFFE JUDGE	C. HUDSON DEPUTY CLERK
	A. HARRIS, CRT ASST
HONORABLE JUDGE PRO TEM	NONE ELECTRONIC RECORDING MONITOR
NONE DEPUTY SHERIFF	DOLHMAN AUDIO VISUAL REPORTER

9:30 a.m. BC181780 Plaintiff
Counsel PATRIC HOOPER, (X)

DOCTOR'S MEDICAL
LABORATORY, IN Defendant
vs. Counsel CHRISTOPHER C. FOLEY (X)
KATHLEEN CONNELL, ETAL.

NATURE OF PROCEEDINGS:

HEARING ON PETITION FOR WRIT OF MANDATE

Matter comes on for hearing and is argued.

Petition for Writ of Mandate is granted part.

Petitioner is not correct in its contention that the Controller has no right to audit petitioner's claims. There is no state or federal law that prohibits the Controller from doing so. The fact that an audit is performed by another state agency does not prohibit the Controller from further checking to see whether that agency is adequately performing its duties.

The issue in this case is NOT whether the Controller can lawfully audit petitioner's claims, but rather whether the Controller can lawfully

withhold payment from petitioner for as long as she chooses to take to complete such an audit.

Controller's argument that such a right to withhold is created by Government Code Section 925.6(a) is also incorrect. The "claim" referred to in Section 925.6(a) is obviously a claim that is presented to the CONTROLLER under Government Code Section 925.4. Petitioner's claims are not presented to the Controller, but to a different state agency which reviews them and, if approved, forwards them to the controller

MINUTES ENTERED
01/12/98
COUNTY CLERK

SUPERIOR COURT OF CALIFORNIA,
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9:30 a.m. BC181780 Plaintiff
Counsel PATRIC HOOPER, (X)
DOCTOR'S MEDICAL
LABORATORY, IN Defendant
vs. Counsel CHRISTOPHER C. FOLEY (X)
KATHLEEN CONNELL, ETAL.

NATURE OF PROCEEDINGS:

for payment.

If the Controller has a right to withhold, it must be because the penalty for late payment under Government Code Section 926.15(a) and interest under Government Code Section 926.19(c) are the exclusive remedies available to petitioner. Neither statute says that the remedy provided for therein is exclusive, and no reason is advanced by the Controller to impute any such intent to the legislature.

When a state agency authorized to do so approves a claim and forwards it to the Controller for payment, the Controller has a ministerial duty to pay the claim within a reasonable time after she receives it. What constitutes a reasonable time in this case is defined by the legistature in Government Code Section 926.15(a): 30 days after receipt of the claim by the Controller from the approving agency. The Controller has that

length of time to determine the amount due and pay it.

Let a writ issue directing the Controller to pay the amounts that she finds due to petitioner within 30 days after receipt of an approved claim from the Department of Health Services. The Controller may deduct from any such payment any part of such claim she finds to be incorrect plus any amount she determines petitioner has been overpaid on prior claims.

MINUTES ENTERED
01/12/98
COUNTY CLERK

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF LOS ANGELES

DATE: 01/12/98	DEPT. 86
HONORABLE DAVID YAFFE JUDGE	C. HUDSON DEPUTY CLERK
	A. HARRIS, CRT ASST
HONORABLE JUDGE PRO TEM	NONE ELECTRONIC RECORDING MONITOR
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9:30 a.m. BC181780

DOCTOR'S MEDICAL LABORATORY, IN
vs.
KATHLEEN CONNELL, ETAL.

Plaintiff
Counsel PATRIC HOOPER, (X)

Defendant
Counsel CHRISTOPHER C. FOLEY (X)

NATURE OF PROCEEDINGS:

Counsel for petitioner to submit proposed judgment with proof of service showing service on opposing counsel. Court will hold 10 days.

MINUTES ENTERED
01/12/98
COUNTY CLERK

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

DOCTOR'S MEDICAL SERVICES, INC. Plaintiff, vs. KATHLEEN CONNELL, CONTROLLER OF THE STATE OF CALIFORNIA Defendant.	Case No. BC181780 JUDGMENT DENYING INJUNCTIVE RELIEF AND GRANTING IN PART AND DENYING IN PART MANDATE RELIEF

The motion of plaintiff, Doctor's Medical Laboratory, Inc. ("Doctor's"), for mandate relief came on regularly for hearing on January 12, 1998, before the Honorable David Yaffee, Judge Presiding, Department 86 of the Superior Court for the County of Los Angeles. Doctor's was represented by Patric Hooper of Hooper, Lundy & Bookman, Inc., and Defendant Kathleen Connell, Controller of the State of California ("Controller"), was represented by Christopher C. Foley. In addition to addressing and resolving the request for mandate relief, the January 12, 1998 hearing and this judgment are intended by the parties and the Court also to resolve any and all other issues raised by Doctor's first amended complaint so that the judgment is considered the final judgment in this proceeding.

The Court having considered the verified complaint, the verified first amended complaint, and exhibits thereto, the answer of the Controller, and the respective parties' memoranda of points and authorities, including exhibits and declarations, and oral argument of counsel, and the Court having issued its tentative decision, hereby orders, adjudges and decrees as follows:

1. Doctor's request for injunctive relief prohibiting the Controller from auditing or reviewing the Medi-Cal claims submitted to, and approved for payment by, the Medi-Cal fiscal intermediary and continuing to withhold the sums at issue is denied;

2. Doctor's request for mandate relief is granted to the extent that the Controller must determine the amount due for any of the Medi-Cal claims submitted by Doctor's, including those previously approved for payment by the Department of Health Services (DH).

3. If the Controller does not issue such determination within thirty days after receipt of a claim approved by the D.H. all claims which have been submitted for payment more than thirty days from the date of this judgment shall be immediately payable and must be released immediately to Doctor's;

4. Except to the extent set forth above, Doctor's request for mandate relief is denied;

5. Doctor's shall be awarded costs in the sum of $_____,

Dated: Jan 29 1998

/s/ David P. Yaffe
JUDGE OF THE SUPERIOR COURT

EXHIBIT C

HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION
Supplement D
Medical Assistance Programs

D-2000. State Organization
D-2100. Single State Agency
D-2110. Provisions of the Act

A. Section 1902(a) of the Social Secur8ity Act reads as follows:

"A State plan for medical assistance must – . . .

"(5) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under title I or XVI (insofar as it relates to the aged);"

. . .

D-2120

HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION
Supplement D
Medical Assistance Programs

D-2100 Single State Agency 6/17/66

D-2120. Requirements for State Plan

A State plan for medical assistance must:

1. Provide for the establishment or designation of a single State agency with authority to administer or supervise the administration of the plan.
2. Include a certification by the attorney general of the State identifying the single State agency and citing the legal authority under which such agency administers, or supervises the administration of, the plan on a State-wide basis including the authority to make rules and regulations governing the administration of the plan by such agency or rules and regulations that are binding on the political subdivisions, if the plan is administered by them.
3. In the event the designated single State agency is other than the State agency administering or supervising the State plan approved under title I or XVI (insofar as it relates to the aged), provide:
   a. That determination of eligibility for medical assistance under the plan will be made by the State or local agency administering such title I or XVI plan in accordance with standards, rules, regulations, and policies established by the single State agency administering or supervising the medical assistance program, and
   b. That there is a written agreement between the two State agencies, showing the relationships and respective responsibilities of the two agencies.

. . .

H.T. No. 83

HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION
Supplement D
Medical Assistance Programs

D-2130. Criteria for the Administration of the Plan

1. There are no State statutes, executive orders, local ordinances, or operations that impair the authority of the designated single State agency.

2. In relationships with other departments of State government, the single State agency interprets its role in such a way that it does not delegate to other than its own officials its requisite ultimate authority for exercising administrative judgment in the State-wide administration of supervision of the plan.

3. In the event that any rules and regulations or decisions of the single State agency are subject to review, clearance, or other action by the offices or agencies of the State government, the requisite authority of the single State agency is not impaired.

4. In the event that any services are performed for the single State agency by other State or local agencies or offices, such other agencies or offices are not authorized to, and do not, change, disapprove, or delay action on any administrative decision of the single State agency, or otherwise substitute their judgment for that of the agency as to the application of policies, rules, and regulations promulgated by the State agency.

5. Any agreements with other public agencies or private organizations to act as the single State agency's agent include provisions for the single State agency obtaining from the agent the data needed for program planning, evaluation, reporting, and accounting purposes and do not in any way impair the ultimate authority of the single State agency.

6. If the single State agency is other than the one responsible for the State plan for the aged under title I or XVI, the written agreement between the two agencies indicates how the two agencies will work together in meeting all pertinent requirements, including the following specific subjects: determination of eligibility, provision of social services, fair hearings, nondiscrimination, staffing, training, maintenance of records, submittal of reports, exchange of information, and review of operations.

PUBLISHER'S NOTE:

Page(s) App 55 **missing in original.**

as the State fiscal officer and the State civil service agency, may perform services for the single State agency that are essential to the operation of the plan. Another agency or authority of government in the State, however, may not be authorized in the plan, or permitted in practice, to substitute its judgment for that of the "single State agency" in administrative decisions involving the application of the policies, rules, and regulations promulgated by the State agency. Similarly, if local agencies administer the plan, the "single State agency" must see that the authority of such agencies to make administrative decisions under the medical assistance law is not impaired by the action of other agencies or officials of State or local governments.

The State agency is also subject to judicial procedures but they must be such that the functions of the "single State agency" as the administrative body, are not impaired. The finding of facts regarding the extent of medical assistance needed, for example, is an administrative function. The courts may properly hold that the State agency has incorrectly applied the law to the facts, or that its findings are arbitrary, capricious, or unreasonable, or are based on insufficient evidence. However, the determination of pertinent facts is a function of the administrative agency and when the evidence is not complete, the State agency is responsible for developing additional evidence and further findings. In such situations, the case is returned to the State agency through a remand by the court.

The "single State agency" is responsible for any services that are performed by other agencies in the program under the plan. This does not mean that the State agency takes over or directs such services. The agency, however, must take such steps as may be necessary in the State to assure that the services, as performed in the medical assistance program, meet the Federal requirements.

The provision does not prevent a State from setting up its own administrative organization to include such programs within one State department as the State feels desirable. The State may designate the same agency as the "single State agency" for more than one of the State plans and authorize that agency to administer other State and Federal-State programs.

In the interests of efficiency and better services to recipients, the "single State agency" may make arrangements with other State agencies or private organizations to act as its agent (a) in providing medical care and services under the State plan, (b) in making agreements with suppliers, and (c) in making arrangements as to payments of suppliers. In such case, the "single State agency" must be able to obtain from the agent the data needed for program planning, evaluation, reporting and accounting purposes. Also, the "single State agency" must be in a position to take such steps as necessary to assure that operations under such arrangements meet Federal requirements.

The State agency has continuing responsibility for the quantity, quality, utilization, and payment for services provided to recipients whether the agency makes arrangements directly with the vendors or uses an agent to make these arrangements. This responsibility may not be abrogated or delegated to others.

The law permits a State agency other than the one responsible for the plan for the aged under title I or XVI, such as a health agency, to be designated the single State agency. The single State agency (if it is other than such title I or XVI agency) has a limitation on its areas of authority for operation of the plan. There must be appropriate arrangements with the State or local agency administering title I or XVI (insofar as it relates to the aged) for that agency to carry out the function of eligibility determination. Such State or local agency will be administering and applying the eligibility standards of the single State agency administering title XIX and will be carrying out day to day operations of these

provisions of the plan. It is necessary that the two State agencies reach an understanding of their distinctive responsibilities and work cooperatively on proper and efficient operation of the State's plan for providing medical assistance to needy individuals.

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
DIVISION: 5

DATE: May 7, 2001

Office of the Attorney General
Patricia Nagler
300 South Spring Street
5th Floor
Los Angeles, CA 90013-1204

RCJ Medical Services, Inc.
v.
The Director of the State Department of Health Services

B143160
Los Angeles County No. BS060056

THE COURT:

Appellants' request for judicial notice filed March 1, 2001, and Supplemental Motion for Judicial Notice filed May 3, 2001, are GRANTED.

IN THE
SUPREME COURT OF THE STATE OF CALIFORNIA

RCJ MEDICAL SERVICES, INC. Respondent, v. THE DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES, Appellant.	Case No. B143160

Los Angeles County Superior Court Case No. BS060056
The Honorable David P. Yaffe

PETITION FOR REVIEW OF THE DECISION OF THE COURT OF APPEAL, SECOND APPELLATE DISTRICT

PATRIC HOOPER (SBN 57343)
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Attorneys for Respondent
RCJ Medical Services, Inc.

IN THE
SUPREME COURT OF THE STATE OF CALIFORNIA

RCJ MEDICAL SERVICES, INC. Respondent, v. THE DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES, Appellant.	Case No. B143160

TO THE HONORABLE RONALD GEORGE, CHIEF JUSTICE, AND TO THE HONORABLE ASSOCIATE JUSTICES OF THE SUPREME COURT OF CALIFORNIA:

Respondent, RCJ Medical Services, Inc. ("RCJ"), respectfully petitions this Court for review of the decision of the Court of Appeal, Second Appellate District, Division 5, (Per Turner, P.J.) filed on August 23, 2001, reversing the judgment of the superior court. Review is necessary to secure uniformity of decision and to settle important questions of law.

QUESTIONS PRESENTED

The two questions of law presented by this petition are:

6. Whether the controlling federal Medicaid regulation, 42 C.F.R. Section 431.10(e), permits the State Department of Health Services ("State DHS"), the single state Medicaid agency in California, to delegate to the State Controller the authority to perform audits of providers of Medi-Cal services; and

7. Whether the federal government's December 17, 1999, approval of State DHS' Medicaid State Plan Amendment specifying that State DHS has delegated audit authority to the State Controller is

applicable to the Medi-Cal audit at issue in this case since the State Controller commenced and completed the audit prior to July 1, 1998, the effective date of the federal approval.

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF LOS ANGELES

DATE: 2/20/02	DEPT. 86
HONORABLE DAVID YAFFE JUDGE	C. HUDSON DEPUTY CLERK
	A. HARRIS, CRT ASST
HONORABLE JUDGE PRO TEM	NONE ELECTRONIC RECORDING MONITOR
NONE DEPUTY SHERIFF	DOLHMAN AUDIO VISUAL REPORTER

9:30 a.m. BS060056

RCJ MEDICAL SERVICES, INC.
vs.
DIRECTOR OF THE STATE DEPARTMENT

Plaintiff
Counsel PATRIC HOOPER, (X)

Defendant
Counsel SANDRA L. GOLDSMITH (X)

NATURE OF PROCEEDINGS:

STATUS CONFERENCE

Status conference is held.

Petitioner shall file and serve an opening brief on or before March 20, 2002.

Respondent shall file and serve an opposing brief on or before April 10, 2002.

Petitioner may file and serve a reply brief on or before April 17, 2002.

All briefs to be served by hand delivery or FAX.

A hearing on the merits is set for April 26, 2002 at 9:30 a.m. in this department.

Petitioner to give notice.

SUPERIOR COURT OF THE STATE OF CALIFORNIA
THE COUNTY OF LOS ANGELES

DEPARTMENT NO. 86 HON. DAVID P. YAFFE, JUDGE

RCJ MEDICAL SERVICES, INC.,	)	
	)	
PETITIONER,	)	
VS.	)	NO. BS 060056
DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES,	)	
	)	
RESPONDENT.	)	
	)	

REPORTER'S TRANSCRIPT OF PROCEEDINGS
WEDNESDAY, FEBRUARY 20, 2002

APPEARANCES:

FOR PETITIONER: HOOPER, LUNDY & BOOKMAN, INC.
BY: PATRIC HOOPER, ESQUIRE
WATT PLAZA, SUITE 1600
1875 CENTURY PARK EAST
LOS ANGELES, CALIFORNIA 90067

FOR RESPONDENT: OFFICE OF THE ATTORNEY GENERAL
BY: SANDRA GOLDSMITH, DEPUTY
300 SOUTH SPRING STREET
SUITE 5000
LOS ANGELES, CALIFORNIA 90013

DARYL CASE, C.S.R. #8739
OFFICIAL REPORTER

LOS ANGELES, CALIFORNIA; WEDNESDAY, FEBRUARY 20, 2002

A. M.. SESSION

DEPARTMENT NO. 86 HON. DAVID P. YAFFE, JUDGE

APPEARANCES: (SEE TITLE PAGE.)

THE COURT: NUMBER FIVE ON THE CALENDAR, RCJ MEDICAL SERVICES VERSUS THE DIRECTOR OF DEPARTMENT OF HEALTH SERVICES.

MR. HOOPER: PATRIC HOOPER, FOR RCJ

MS. GOLDSMITH: SANDRA GOLDSMITH, DEPUTY ATTORNEY GENERAL, FOR THE DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES.

THE COURT: DO WE HAVE TO SET ANOTHER BRIEFING SCHEDULE AND HEARING DATE?

MS. GOLDSMITH: NO, YOUR HONOR. THERE'S A PUBLISHED DECISION BY THE COURT OF APPEAL. THE CASE WAS REVERSED AND NOT EVEN REMANDED, SO - -

THE COURT: WELL, THE EFFECT OF AN UNQUALIFIED REVERSAL, AS I UNDERSTAND IT, IS TO VACATE THE JUDGMENT AND LEAVE THE CASE AT LARGE FOR FURTHER PROCEEDINGS AS IF IT HAD NEVER BEEN TRIED AND AS IF NO JUDGMENT HAD EVER BEEN RENDERED. AT LEAST THAT'S WHAT WITKIN SAYS AT VOLUME 9, THE FOURTH EDITION, AT PAGE 783. SO IS THAT RIGHT?

MR. HOOPER: I LIKE THAT, YOUR HONOR, BUT WE ARE GOING TO PROBABLY PETITION THE U.S. SUPREME COURT IN

ONE LAST-DITCH EFFORT, SO PERHAPS WE COULD CONTINUE THIS FOR ANOTHER SIX MONTHS IF THAT'S POSSIBLE AND - -

THE COURT: WELL, I THINK I'D LIKE - - I THINK I'D LIKE TO KEEP IT ON TRACK HERE BY SCHEDULING IT OUT. I'LL GIVE YOU SOME LEEWAY ON THE OPENING BRIEF, I GUESS, BUT LET'S SCHEDULE IT OUT AND SET A HEARING ON THE MERITS. AT LEAST, I DON'T KNOW WHAT ELSE I CAN DO.

MISS GOLDSMITH.

MS. GOLDSMITH: I DON'T KNOW WHAT'S LEFT TO THE CASE.

MR. HOOPER: WELL, THERE MA' BE SOMETHING LEFT, AND WE WILL CHAT ABOUT IT. WE WILL NOT TRY TO - -

THE COURT: ACCORDING TO WITKIN IT'S AS IF IT HAD NEVER BEEN TRIED.

MS. GOLDSMITH: HE GETS TO FILE ONE PETITION FOR WRIT OF MANDATE, AND IT'S GONE UP, AND IT'S - -

THE COURT: WELL, I MEAN, IF YOU WANT TO SUBMIT IT ON THE SAME BRIEFS THAT YOU SUBMITTED BEFORE, AND YOU BOTH STIPULATE TO THAT, I'LL CERTAINLY ORDER THAT. IF YOU WANT TO FILE NEW BRIEFS, I'LL LET YOU FILE NEW BRIEFS.

MR. HOOPER: I WILL FILE NEW BRIEFS, YOUR HONOR.

THE COURT: WHEN DO YOU WANT TO FILE AN OPENING BRIEF?

MR. HOOPER: AT THE CONVENIENCE OF THE COURT.

WE CAN DO IT --

THE COURT: THIRTY DAYS?

MR. HOOPER: YES.

THE COURT: ALL RIGHT. PETITIONER SHALL FILE AND SERVE AN OPENING BRIEF, THEN, BY MARCH 20TH, 2002.

RESPONDENT: OPPOSING BRIEF APRIL 10, 2002.

PETITIONER MAY FILE AND SERVE A REPLY BRIEF BY APRIL 17TH, 2002.

ALL BRIEFS TO BE SERVED BY HAND DELIVERY OR FAX. HEARING ON THE MERITS, HOW IS APRIL 26TH, 2002 ?

MR. HOOPER: THAT'S FINE, YOUR HONOR.

THE COURT: MISS GOLDSMITH?

MS. GOLDSMITH: THAT'S FINE, YOUR HONOR.

THE COURT: HEARING ON THE MERITS, APRIL 26, 2002. AT 9: 30 A. M. IN THIS DEPARTMENT. NOTICE WAIVED ?

MR. HOOPER: NOTICE WAIVED.

MS. GOLDSMITH: I WOULD LIKE NOTICE

THE COURT: PETITIONER TO GIVE NOTICE.

MR. HOOPER: THANK YOU, VERY MUCH, YOUR HONOR, AND THANK YOU FOR GRANTING PRIORITY.

THE COURT: THANK YOU, BOTH.

(PROCEEDINGS CONCLUDED.)

SUPERIOR COURT OF THE STATE OF CALIFORNIA
THE COUNTY OF LOS ANGELES

DEPARTMENT NO. 86 HON. DAVID P. YAFFE, JUDGE

RCJ MEDICAL SERVICES, INC.,	)	
	)	
PETITIONER,	)	
VS.	)	NO. BS 060056
DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES,	)	
RESPONDENT.	)	
	)	

I, DARYL C. CASE, OFFICIAL REPORTER OF THE SUPERIOR COURT OF THE STATE OF CALIFORNIA, FOR THE COUNTY OF LOS ANGELES, DO HEREBY CERTIFY THAT THE FOREGOING PAGES 1 THROUGH 3, INCLUSIVE, COMPRISE A FULL, TRUE AND CORRECT TRANSCRIPT OF THE TESTIMONY AND PROCEEDINGS TAKEN ON THE ABOVE-ENTITLED MATTER ON WEDNESDAY, FEBRUARY 20, 2002.

DATED THIS 22ND DAY OF FEBRUARY, 2002.

/s/ Daryl C. Case, CSR #8739
OFFICIAL REPORTER

HOOPER, LUNDY & BOOKMAN, INC.
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Attorneys for Petitioner

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

RCJ MEDICAL SERVICES, INC., DBA AMERICAN NETWORK LABORATORY, Petitioner, v. THE DIRECTOR OF THE CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES, Respondent.	) Case No. BS060056)) PETITIONER'S)SUPPLEMENTAL)MEMORANDUM OF)POINTS AND)AUTHORITIES IN)SUPPORT OF MOTION)FOR PEREMPTORY)WRIT OF MANDATE))Date: April 26, 2002)Time: 9:30 a.m.)Dept: 86)

. . .

B. UNDER THE CONTROLLING FEDERAL MEDICAID LAWS, STATE DHS MAY NOT RELY ON THE AUDIT FINDINGS OF THE STATE CONTROLLER IN THIS CASE BECAUSE THE STATE CONTROLLER'S AUDITS PREDATED THE JULY 1, 1998, EFFECTIVE DATE OF THE STATE PLAN AMENDMENT AUTHORIZING THE STATE CONTROLLER TO PERFORM MEDI-CAL AUDITS

In the California state Medicaid Plan submitted to HCFA in 1993, State DHS was identified as the single state Medicaid agency for all purposes, including conducting postpayment audits and reviews of the providers. See 91 Cal.App.4th at 999. While State DHS and the State Controller had entered into a state agreement in 1997 purporting to authorize the State Controller to perform Medi-Cal audits on behalf of State DHS, the State Medicaid Plan was not amended to specify that the State Controller would be conducting Medi-Cal audits until December 17, 1999. As discussed above, at that time State DHS specifically included a new provision in the State Plan specifying for the first time that the State Controller conducted audits on behalf of State DHS. State DHS requested that the State Plan Amendment be made effective July 1, 1998, and HCFA did, in fact, approve the Plan on December 17, 1999, making it effective retroactively as of July 1, 1998, which postdates the State Controller's audits of RCJ in this case.

As this Court is aware, a Medicaid State Plan must contain various provisions required by the controlling federal Medicaid laws and regulations. See 42 U.S.C. §1396a(a)(1)-(65) and 42 C.F.R. §§431.1 et seq. [1999]. As the Court also knows, these federal State Plan requirements are supreme to state law requirements regarding the administration of the Medicaid program. Doctor's Medical Laboratory, Inc. v. Connell, 69 Cal.App.4th 893-894.

When the single state Medicaid agency, here State DHS, decides to delegate authority to other state or local agencies, such as authority for establishing and maintaining health and other standards for providers, these interagency relationships must be described in the State Medicaid Plan. For example, see 42 C.F.R. §431.610(b) and (c) [1999], requiring

a state Medicaid Plan to designate the state authority responsible for establishing and maintaining health standards for providers. In addition to requiring each state Medicaid plan to describe the single state Medicaid agency's relations with other state and local agencies, the State Medicaid Plan must also describe the organization and functions of the single state Medicaid agency, itself, and its personnel and supporting staff. See 42 U.S.C. §1396a(a)(22) and 42 C.F.R. §431.11(c) [1999].[2/]

Importantly, when there are material changes in the organization or policy of the state Medicaid agency, a state plan amendment must be submitted by the single state agency and approved by HCFA. See 42 C.F.R. §430.12(c)(22) and 42 C.F.R. §431.11(c) [1999]. When plan amendments do not affect Medicaid eligibility or payment methods or standards, the plan amendments may become effective on the date requested by the single state Medicaid agency so long as HCFA approves the plan amendment. See 42 C.F.R. §430.20(b)(3) [1999]. As indicated above, the State Plan Amendment at issue became effective July 1, 1998, several months after the Controller completed her audits of RCJ.

The courts have consistently prohibited actions by Medicaid state agencies which are unauthorized by the state's then-existing Medicaid plan. See, for example, Exeter Memorial Hospital Ass'n v. Belshe, 943 F.Supp. 1239, 1240 (E.D. Cal. 1996), Affirmed, 145 F.3d 1106, 1109 (9th Cir. 1998) [the Court prohibits State DHS' action from being implemented prior to the effective date of a state plan amendment], and Oregon Association of Homes v. State Department of Human Resources, 5 F.3d 1239 (9th Cir. 1993) [state Medicaid policy invalid because it was not submitted as a plan amendment to the federal government]. See also, Washington State Health Facilities v. DSHS, 879 F.2d 677 (9th Cir. 1989).[3/]

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2. The relevant provisions of the governing federal Medicaid regulations are attached hereto as Exhibit A..

3. Copies of these federal authorities are attached as Exhibit B.

In addition to these federal court cases, the California Corut of Appeal has also recognized the importance of state plan amendments. For example, in Bingham v. Obledo (1983), 147 Cal.App.3d 401, the California Court of Appeal expressly invalidated State DHS' Medi-Cal practice regarding coverage of patient transportation services because it was not included in the State Medicaid Plan, as it then existed.

In this case, State DHS has relied on and upheld the findings of the State Controller even though the State Controller's audits of RCJ predated the State Plan Amendment permitting the State Controller for the first time to perform Medi-Cal audits on behalf of State DHS. In fact, at the time the State Controller performed the audits at issue, the State Medicaid Plan specified that only State DHS could perform Medi-Cal audits. Thus, the State Controller's audit findings must be deemed to be void and invalid because they were not authorized by the provisions of the State Plan then in effect.

Contrary to the assertion of State DHS (Respondent's March 8, 2002 Reply, pp. 5-6), the Court of Appeal did not address the issue of the impact of the pre-July 1, 1998, State Plan on the audit authority of the State Controller in its August 23, 2001, decision. While emphasizing the importance of HCFA's approval of the December 17, 1999, Plan Amendment on the Court's interpretation of the single state agency requirement, the Court did not address the consequences of the Plan Amendment's effective date of July 1, 1998, on the pre-July 1, 1998, audit findings in this case.[4/] As a result, the Court of Appeal's decision of August 23, 2001, cannot be considered to be the "law of the case" regarding the very important and distinct issue of whether the 1999 Plan Amendment permits an audit by the Controller prior to July 1, 1998. This is especially true because the effective date issue presents a separate question of federal law. (See Witkin, California Procedure, Appeal, Section 896 (4th Ed., 1997).

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4. The Court only analyzed the issue of the effect of the Plan Amendment in the context of the deference question. 91 Cal.App.4th at 1004.

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SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

RCJ MEDICAL SERVICES, INC. dba AMERICAN NETWORK LABORATORY, Petitioner,	)Case No. BS 060056)) NOTICE OF)CONTINUANCE)OF HEARING
v.	)
THE DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES, Respondent.	)Date: May 6, 2002)Time: 9:30 a.m.)Dept: 86))

TO THE DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES AND TO HER ATTORNEY OF RECORD, SANDRA GOLDSMITH, DEPUTY ATTORNEY GENERAL:

PLEASE TAKE NOTICE that on April 12, 2002, the Court, on its own motion, reset the hearing on the Writ of Mandate, previously scheduled for April 26, 2002, to May 6, 2002, at 9:30 a.m., in Department 86 of the Superior Court, 111 North Hill Street, Los Angeles, California 90012.

Dated: April 16, 2002

Respectfully submitted,
HOOPER, LUNDY & BOOKMAN, INC.
PATRIC HOOPER

By: /s/ Patric Hooper
Patric Hooper
Attorneys for Petitioner
RCJ Medical Services, Inc.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
DIVISION FIVE

DOCTOR'S MEDICAL SERVICES, INC., Plaintiff, Respondent and Cross-Appellant, vs. THE DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES, Defendant, Appellant., and Cross-Respondent.	Case No. B142529 (Super. Ct. No. BS060054)

APPEAL from a judgment of the Superior Court of Los Angeles County, David P. Yaffe, Judge. Reversed.

Bill Lockyer, Attorney General, Charlton G. Holland, III, Senior Assistant Attorney General, John H. Sanders, Lead Supervising Deputy Attorney General, Tammy Chung Ryu, Supervising Deputy Attorney General, and Sandra L. Goldsmith, Deputy Attorney General, for Plaintiff, Respondent, and Cross-Appellant.

Hooper, Lundy & Bookman, Inc. and Patric Hooper for Defendant, Appellant, and Cross-Respondent.

The present appeal involves a dispute between Doctor's Laboratory, Inc., a Medicaid provider, and the Director of the State Department of Health Services (the director) over the legality of an audit conducted by the State Controller given the single state agency requirement of title 42 United States Code section 1369a(a)(5). All of the issues posited by the parties concerning the single state agency requirement are conclusively resolved by our opinion in *RCJ Medical Services, Inc. v. Bontá* (2001) 91 Cal.App.4th 986, 992-1015, a decision where review was denied by the California Supreme Court on December 12, 2001. In *RCJ Medical*

Services, we upheld an audit by the State Controller as was performed here. We reiterate our analysis in *RCJ Medical Services* in this case and reverse the trial court's order setting aside the audit findings of the State Controller premised on the single state agency requirement of title 42 United States Code section 1369a(a)(5). Accordingly, on direct appeal, the judgment, which disapproved the audit, is reversed.

The provider has cross-appealed contending it is entitled to attorney fees pursuant to 42 United States Code section 1988 because it succeeded in the trial court in vacating the audit findings. However, we have reversed the order vacating the audit findings which now renders the provider's attorney fee claim to be meritless.

The April 28, 2000, judgment granting the mandate petition is reversed. The Director of the State Department of Health Services is to recover her costs incurred on appeal from Doctor's Laboratory, Inc.

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TURNER, P.J.

We concur.

GRIGNON, J. ARMSTRONG, J.

28 U.S.C. §1257. State courts; certiorari

(a) Final judgments or decrees rendered by the highest court of a State in which a decision could be had, may be reviewed by the Supreme Court by writ of certiorari where the validity of a treaty or statute of the United States is drawn in question or where the validity of a statute of any State is drawn in question on the ground of its being repugnant to the Constitution, treaties, or laws of the United States, or where any title, right, privilege, or immunity is specially set up or claimed under the Constitution or the treaties or statutes of, or any commission held or authority exercised under, the United States.

42 U.S.C. §1396a(a)(42). State plans for medical assistance.

provide that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan;

42 C.F.R. §430.0 Program description.

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

42 C.F.R. §430.1 Scope of subchapter C.

The regulations in subchapter C set forth State plan requirements, standards, procedures, and conditions for obtaining Federal financial participation. (F.F.P.) Each part (or subpart of section) in the subchapter describes the specific statutory basis for the regulation. However, where the basis is the Secretary's general authority to issue regulations for any program under the Act (section 1102 of the Act), or his general authority to prescribe State plan requirements needed for proper and efficient administration of the plan (section 1902(a)(4)), those statutory provisions are simply cited without further description.

42 C.F.R. §431.107 Required provider agreement.

(a) *Basis and purpose.* This section sets forth State plan requirements, based on sections 1902(a)(4), 1902(a)(27), 1902(a)(57), and 1902(a)(58) of the Act, that relate to the keeping of records and the furnishing of information by all providers of services (including individual practitioners and groups of practitioners).

(b) *Agreements.* A State plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to:

(1) Keep any records necessary to disclose the extent of services the provider furnishes to recipients;

(2) On request, furnish to the Medicaid agency, the Secretary, or the State Medicaid fraud control unit (if such a unit has been approved by the Secretary under §455.300 of this chapter), any information maintained under paragraph (b)(1) of this section and any information regarding payments claimed by the provider for furnishing services under the plan;

(3) Comply with the disclosure requirements specified in part 455, sub-part B of this chapter; and

(4) Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMO's specified in part 489, subpart I, and §417.436(d) of this chapter.

42 C.F.R. §431.108 Effective date of provider agreements.

(a) *Applicability*– (1) *General rule.* Except as provided in paragraph (a)(2) of this section applies to Medicaid provider agreements with entitles that, as a basis for participation in Medicaid–

(i) Are subject to survey and certification by HCFA or the State survey agency; or

(ii) Are deemed to meet Federal; requirements on the basis of accreditation by an accrediting organization whose program has HCFA approval at the time of accreditation survey and accreditation decision.

(2) *Exception.* A Medicaid provider agreement with a laboratory is effective only while the laboratory has in effect a valid CLIA certificate issued under part 493 of this chapter, and only for the specialty and subspecialty tests it is authorized to perform

(b) *All requirements are met on the date of survey.* The agreement is effective on the date the onsite survey (including the Life Safety Code survey if applicable) is completed, if on that date the provider meets–

(1) All applicable Federal requirements as set forth in this chapter; and

(2) Any other requirements imposed by the State for participation in the Medicaid program. (If the provider has a time-limited agreement,

the new agreement is effective on the day following expiration of the current agreement.)

(c) *All requirements are not met on the date of survey.* If on the date the survey is completed the provider fails to meet any of the requirements specified in paragraph (b) of this section, the following rules apply:

(1) An NF provider agreement is effective on the date on which–

(i) The NF is found to be in substantial compliance as defined in §488.301 of this chapter; and

(ii) HCFA or the State survey agency receives from the NF, if applicable, an approval waiver request.

(2) For an agreement with any other provider, the effective date is the earlier of the following:

(i) The date on which the provider meets all requirements.

(ii) The date on which a provider is found to meet all conditions of participation but has lower level deficiencies, and HCFA or the State survey agency receives from the provider an acceptable plan of correction for the lower level deficiencies, or an approvable waiver request, or both. (The date of receipt is the effective date of the agreement, regardless of when HCFA approves the plan of correction or waiver request, or both.)

(d) *Accredited provider requests participation in the Medicaid program*–(1) *General rule.* If a provider is currently accredited by a national accrediting organization whose program had HCFA approval at the time of accreditation survey and accreditation decision, and on the basis of accreditation, HCFA has deemed the provider to meet Federal requirements, the effective date depends on whether the provider is subject to requirements in addition to those included in the accrediting organization's approved program.

(i) *Provider subject to additional requirements.* For a provider that is subject to additional requirements, Federal or State, or both, the effective date is the date on which t he provider meets all requirements, including the additional requirements.

(ii) *Provider not subject to additional requirements.* For a provider that is not subject to additional requirements, the effective date is the date of the provider's initial request for participation if on that